

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0048

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/27/2021 8:39 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/27/2021	Time: 8:39 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 ADVOCATE SOUTHLAND HOSPITAL (14-0048) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHAEL VOLANTE

Officer or Administrator of Provider(s)

VICE PRESIDENT REIMBURSEMENT

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	156,840	-151,173	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	156,840	-151,173	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: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/27/2021 8:39 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2320 E. 93RD ST.			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60617-		County: COOK	
		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			ADVOCATE SOUTHLAND HOSPITAL	140048	16974	1	07/01/1966	N
4.00	Subprovider - IPF							P	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
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)						01/01/2020	12/31/2020	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	Y		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)					N	N	N	22.03
23.00	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.								
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,431	2,222	0	0	4,160	149

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

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

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

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
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	
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					115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					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.	0					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	285,222	300,000	3,556,285	118.01		
						1.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/27/2021 8:39 am		
			1.00		2.00				
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	148036	140.00	
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: ADVOCATE HEALTHCARE		Contractor's Name: NATIONAL GOVT SERV		Contractor's Number: 06101			141.00	
142.00	Street: 3075 HIGHLAND PARKWAY SUITE 600		PO Box:					142.00	
143.00	City: DOWNERS GROVE		State: IL		Zip Code: 60515			143.00	
							1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
							1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
							1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
			Part A	Part B	Title V	Title XIX			
			1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital		N	N	N	N		155.00	
156.00	Subprovider - IPF		N	N	N	N		156.00	
157.00	Subprovider - IRF		N	N	N	N		157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF		N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY		N	N	N	N		160.00	
161.00	CMHC			N	N	N		161.00	
161.10	CORF			N	N	N		161.10	
							1.00		
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
			Name	County	State	Zip Code	CBSA	FTE/Campus	
			0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/27/2021 8:39 am
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 5/27/2021 8:39 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		03/22/2021		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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.	Y					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.	Y					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/06/2021	Y	05/06/2021		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		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		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 5/27/2021 8:39 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	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		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.	SCOTT	MITCHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTH CARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5761	SCOTT.MITCHELL@ADVOCATEHEALT H.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 5/27/2021 8:39 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.	SR. REIMBURSEMENT SPECIALIST		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: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/27/2021 8:39 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	199	72,834	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		199	72,834	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	26	9,516	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		225	82,350	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		225				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: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/27/2021 8:39 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)	6,281	3,634	25,082		1.00
2.00	HMO and other (see instructions)	8,889	4,160			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)	6,281	3,634	25,082		7.00
8.00	INTENSIVE CARE UNIT	1,404	944	6,489		8.00
9.00	CORONARY CARE UNIT	0	0	0		9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		75	433		13.00
14.00	Total (see instructions)	7,685	4,653	32,004	0.00	694.00
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	16.00
18.00	SUBPROVIDER		0	0	0.00	17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			231		24.00
25.00	CMHC - CMHC					24.10
25.10	CMHC - CORF	0	0	0	0.00	25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	25.10
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	0.00
28.00	Observation Bed Days		226	6,566		0.00
29.00	Ambulance Trips	0				694.00
30.00	Employee discount days (see instruction)			0		28.00
31.00	Employee discount days - IRF			0		29.00
32.00	Labor & delivery days (see instructions)	0	149	182		30.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		31.00
33.00	LTCH non-covered days	0				32.00
33.01	LTCH site neutral days and discharges	0				32.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/27/2021 8:39 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,564	332	7,336	1.00
2.00 HMO and other (see instructions)			1,830	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,564	332	7,336	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
5/27/2021 8:39 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	57,460,447	0	57,460,447	1,438,838.00	39.94 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		142,146	2,917	145,063	3,910.00	37.10 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,961,261	0	1,961,261	22,267.00	88.08 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		1,618,697	0	1,618,697	13,702.00	118.14 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		7,678,274	0	7,678,274	112,402.00	68.31 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,925,995	0	15,925,995		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		6,684	0	6,684		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,705,245	0	1,705,245		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
5/27/2021 8:39 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	472,806	-444,000	28,806	1,914.00	15.05	26.00
27.00	Administrative & General	5.00	7,588,166	-3,877,934	3,710,232	121,701.00	30.49	27.00
28.00	Administrative & General under contract (see inst.)		885,474	0	885,474	4,796.29	184.62	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	140	10,074	10,214	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	8,489	8,489	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	7,378	7,378	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,507,760	289,408	4,797,168	96,366.00	49.78	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,757,373	16,114	2,773,487	48,360.00	57.35	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
5/27/2021 8:39 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	58,345,921	0	58,345,921	1,443,634.29	40.42	1.00
2.00	Excluded area salaries (see instructions)	142,146	2,917	145,063	3,910.00	37.10	2.00
3.00	Subtotal salaries (line 1 minus line 2)	58,203,775	-2,917	58,200,858	1,439,724.29	40.43	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,258,232	0	11,258,232	148,371.00	75.88	4.00
5.00	Subtotal wage-related costs (see inst.)	17,631,240	0	17,631,240	0.00	30.29	5.00
6.00	Total (sum of lines 3 thru 5)	87,093,247	-2,917	87,090,330	1,588,095.29	54.84	6.00
7.00	Total overhead cost (see instructions)	16,211,719	-3,990,471	12,221,248	273,137.29	44.74	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
5/27/2021 8:39 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,017,084	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)	227,147	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)	5,251,173	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,309,458	9.00
10.00	Dental, Hearing and Vision Plan	101,075	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	42,677	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)	600,314	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	326,100	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,227,874	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	341,121	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))	45,994	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	442,662	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,932,679	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,961,261	15,932,679	1.00
2.00	Hospital	1,961,261	15,932,679	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 5/27/2021 8:39 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)			0.287530	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			25,061,177	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			165,437,095	6.00
7.00	Medicaid cost (line 1 times line 6)			47,568,128	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)			22,506,951	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			22,506,951	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)	22,213,586	684,926	22,898,512	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	6,387,072	684,926	7,071,998	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	6,387,072	684,926	7,071,998	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			12,286,760	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			692,383	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,065,204	27.01
28.00	Non-Medicare bad debt expense (see instructions)			11,221,556	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,599,355	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			10,671,353	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			33,178,304	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0048

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

Worksheet A

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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	NEW CAP REL COSTS-BLDG & FIXT		0	0	7,274,707	7,274,707	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	2,690,950	2,690,950	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	472,806	9,428,112	9,900,918	1,330,475	11,231,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,588,166	52,594,122	60,182,288	-15,369,364	44,812,924	5.00
7.00	00700	OPERATION OF PLANT	140	8,694,053	8,694,193	-72,130	8,622,063	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	706,671	706,671	0	706,671	8.00
9.00	00900	HOUSEKEEPING	0	2,517,743	2,517,743	-414	2,517,329	9.00
10.00	01000	DIETARY	0	3,079,263	3,079,263	-1,185,128	1,894,135	10.00
11.00	01100	CAFETERIA	0	0	0	1,139,327	1,139,327	11.00
13.00	01300	NURSING ADMINISTRATION	4,507,760	910,712	5,418,472	261,881	5,680,353	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,757,373	8,266,557	11,023,930	-7,058,929	3,965,001	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	107,582	107,582	-87	107,495	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,442,007	6,018,100	22,460,107	510,731	22,970,838	30.00
31.00	03100	INTENSIVE CARE UNIT	4,840,446	3,279,053	8,119,499	-763,522	7,355,977	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	517,993	169,267	687,260	131,779	819,039	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,599,857	7,254,635	10,854,492	-5,909,017	4,945,475	50.00
51.00	05100	RECOVERY ROOM	594,531	87,541	682,072	29,130	711,202	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,404	2,686,939	2,732,343	-218,374	2,513,969	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,541,605	1,537,400	5,079,005	-576,882	4,502,123	54.00
56.00	05600	RADIOISOTOPE	343,647	599,889	943,536	-536,178	407,358	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	971,637	3,233,933	4,205,570	-2,301,624	1,903,946	59.00
60.00	06000	LABORATORY	0	7,726,076	7,726,076	66,025	7,792,101	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,284,200	611,637	1,895,837	-128,403	1,767,434	65.00
66.00	06600	PHYSICAL THERAPY	1,342,310	502,087	1,844,397	126,679	1,971,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,042,308	266,176	1,308,484	-7,607	1,300,877	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,585	12,153	58,738	477	59,215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,736,334	8,736,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,854,996	4,854,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,799,202	7,799,202	73.00
74.00	07400	RENAL DIALYSIS	881,340	327,033	1,208,373	-48,890	1,159,483	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	213,407	22,013	235,420	32,944	268,364	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	704,972	458,985	1,163,957	-61,617	1,102,340	90.00
91.00	09100	EMERGENCY	5,579,807	2,929,390	8,509,197	-723,959	7,785,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,318,301	124,027,122	181,345,423	23,512	181,368,935	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	142,146	147,111	289,257	-23,512	265,745	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	57,460,447	124,174,233	181,634,680	0	181,634,680	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0048

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

Worksheet A

Date/Time Prepared:
5/27/2021 8:39 am

	Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	68,701	7,343,408	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	916,784	3,607,734	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,478,996	13,710,389	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,043,686	34,769,238	5.00
7.00	00700	OPERATION OF PLANT	-66,633	8,555,430	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	706,671	8.00
9.00	00900	HOUSEKEEPING	0	2,517,329	9.00
10.00	01000	DIETARY	0	1,894,135	10.00
11.00	01100	CAFETERIA	-367,946	771,381	11.00
13.00	01300	NURSING ADMINISTRATION	-36,848	5,643,505	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-1,280	3,963,721	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	107,495	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,506,418	20,464,420	30.00
31.00	03100	INTENSIVE CARE UNIT	-2,441	7,353,536	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-50,000	769,039	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,357	4,944,118	50.00
51.00	05100	RECOVERY ROOM	0	711,202	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-2,454,067	59,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-311	4,501,812	54.00
56.00	05600	RADIOISOTOPE	-249	407,109	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	-748,827	1,155,119	59.00
60.00	06000	LABORATORY	-205,048	7,587,053	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-8,022	1,759,412	65.00
66.00	06600	PHYSICAL THERAPY	-32,181	1,938,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-3,190	1,297,687	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	59,215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,736,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,854,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,799,202	73.00
74.00	07400	RENAL DIALYSIS	0	1,159,483	74.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	268,364	76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	1,102,340	90.00
91.00	09100	EMERGENCY	-54,668	7,730,570	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				
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,118,691	168,250,244	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	-13,135	252,610	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,131,826	168,502,854	200.00

RECLASSIFICATIONS

Provider CCN: 14-0048

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

Worksheet A-6

Date/Time Prepared:
5/27/2021 8:39 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - COST OF DRUGS 9929					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,716,449	1.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
	TOTALS		0	7,716,449		
	C - MEDICAL SUPPLIES 9929					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,591,330	1.00	
2.00		0.00	0	0	2.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
	TOTALS		0	13,591,330		
	D - DERPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,274,707	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,690,950	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	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	

RECLASSIFICATIONS

Provider CCN: 14-0048

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

Worksheet A-6

Date/Time Prepared:
5/27/2021 8:39 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
27.00	0.00	0	0		27.00
28.00	0.00	0	0		28.00
TOTALS		0	9,965,657		
E - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	0	1,139,327	1.00
TOTALS		0	1,139,327		
F - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,854,996	1.00
TOTALS		0	4,854,996		
G - INCENTIVE COMP					
1.00	ADMINISTRATIVE & GENERAL	5.00	218,439	0	1.00
2.00	OPERATION OF PLANT	7.00	10,074	0	2.00
4.00	HOUSEKEEPING	9.00	8,489	0	4.00
5.00	NURSING ADMINISTRATION	13.00	38,124	0	5.00
6.00	DIETARY	10.00	7,378	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	85,704	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	11,107	0	8.00
10.00	OPERATING ROOM	50.00	11,124	0	10.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	9,837	0	13.00
14.00	EMERGENCY	91.00	8,494	0	14.00
15.00	RESPIRATORY THERAPY	65.00	10,162	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	8,954	0	16.00
17.00	PHARMACY	15.00	16,114	0	17.00
TOTALS			444,000	0	
H - COVID EXPENSE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,775,609	1.00
2.00	NURSING ADMINISTRATION	13.00	251,284	162,655	2.00
3.00	ADULTS & PEDIATRICS	30.00	1,318,476	680,737	3.00
4.00	INTENSIVE CARE UNIT	31.00	510,833	202,970	4.00
5.00	NURSERY	43.00	164,739	45,899	5.00
6.00	OPERATING ROOM	50.00	322,913	164,138	6.00
7.00	RECOVERY ROOM	51.00	37,249	20,158	7.00
8.00	ANESTHESIOLOGY	53.00	6,850	4,136	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	237,755	143,018	9.00
10.00	RADIOISOTOPE	56.00	27,014	10,857	10.00
11.00	CARDIAC CATHETERIZATION	59.00	55,008	36,475	11.00
12.00	LABORATORY	60.00	0	595,732	12.00
13.00	RESPIRATORY THERAPY	65.00	142,495	59,057	13.00
14.00	PHYSICAL THERAPY	66.00	108,991	31,475	14.00
15.00	ELECTROCARDIOLOGY	69.00	43,141	27,971	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	5,108	3,343	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	51,219	31,534	17.00
18.00	RENAL DIALYSIS	74.00	136,527	39,352	18.00
19.00	CARDIAC REHABILITATION	76.97	23,828	12,642	19.00
20.00	CLINIC	90.00	39,028	44,620	20.00
21.00	EMERGENCY	91.00	610,998	242,801	21.00
22.00	NONREIMBURSABLE COST CENTERS	194.00	2,917	700	22.00
TOTALS			4,096,373	4,335,879	
500.00	Grand Total: Increases		4,540,373	41,603,638	500.00

RECLASSIFICATIONS

Provider CCN: 14-0048

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

Worksheet A-6

Date/Time Prepared:
5/27/2021 8:39 am

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	B - COST OF DRUGS 9929							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,673	0		1.00	
3.00	NONREIMBURSABLE COST CENTERS	194.00	0	11	0		3.00	
4.00	PHARMACY	15.00	0	6,954,018	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	195,340	0		5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	90,516	0		6.00	
7.00	NURSERY	43.00	0	678	0		7.00	
8.00	OPERATING ROOM	50.00	0	16,365	0		8.00	
9.00	RECOVERY ROOM	51.00	0	2,142	0		9.00	
10.00	ANESTHESIOLOGY	53.00	0	13,510	0		10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	40,187	0		11.00	
12.00	RADIOISOTOPE	56.00	0	59,987	0		12.00	
13.00	CARDIAC CATHETERIZATION	59.00	0	13,466	0		13.00	
14.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,034	0		14.00	
15.00	LABORATORY	60.00	0	571	0		15.00	
16.00	ELECTROCARDIOLOGY	69.00	0	2,264	0		16.00	
17.00	RENAL DIALYSIS	74.00	0	8,837	0		17.00	
18.00	CLINIC	90.00	0	8,358	0		18.00	
19.00	EMERGENCY	91.00	0	300,492	0		19.00	
	TOTALS		0	7,716,449				
	C - MEDICAL SUPPLIES 9929							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,428	0		1.00	
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	100	0		2.00	
6.00	NURSING ADMINISTRATION	13.00	0	2,408	0		6.00	
7.00	PHARMACY	15.00	0	41,639	0		7.00	
8.00	NONREIMBURSABLE COST CENTERS	194.00	0	21,872	0		8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	1,143,090	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	1,049,402	0		10.00	
11.00	NURSERY	43.00	0	35,040	0		11.00	
12.00	OPERATING ROOM	50.00	0	5,902,107	0		12.00	
13.00	RECOVERY ROOM	51.00	0	20,910	0		13.00	
14.00	ANESTHESIOLOGY	53.00	0	126,241	0		14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	386,606	0		15.00	
16.00	RADIOISOTOPE	56.00	0	434,607	0		16.00	
17.00	CARDIAC CATHETERIZATION	59.00	0	2,024,549	0		17.00	
18.00	LABORATORY	60.00	0	525,914	0		18.00	
19.00	RESPIRATORY THERAPY	65.00	0	286,733	0		19.00	
20.00	PHYSICAL THERAPY	66.00	0	12,229	0		20.00	
23.00	ELECTROCARDIOLOGY	69.00	0	16,741	0		23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,951	0		24.00	
25.00	RENAL DIALYSIS	74.00	0	204,016	0		25.00	
26.00	CARDIAC REHABILITATION	76.97	0	1,994	0		26.00	
27.00	CLINIC	90.00	0	133,707	0		27.00	
28.00	EMERGENCY	91.00	0	1,190,046	0		28.00	
	TOTALS		0	13,591,330				
	D - DERPRECIATION EXPENSE							
1.00		0.00	0	0	9		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,120,450	9		2.00	
3.00	OPERATION OF PLANT	7.00	0	82,204	0		3.00	
4.00	HOUSEKEEPING	9.00	0	8,903	0		4.00	
5.00	DIETARY	10.00	0	53,179	0		5.00	
6.00	NURSING ADMINISTRATION	13.00	0	187,774	0		6.00	
7.00	PHARMACY	15.00	0	79,386	0		7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	87	0		8.00	
10.00	ADULTS & PEDIATRICS	30.00	0	235,756	0		10.00	
11.00	INTENSIVE CARE UNIT	31.00	0	348,514	0		11.00	
12.00	NURSERY	43.00	0	43,141	0		12.00	
13.00	OPERATING ROOM	50.00	0	488,720	0		13.00	
14.00	RECOVERY ROOM	51.00	0	5,225	0		14.00	
15.00	ANESTHESIOLOGY	53.00	0	89,609	0		15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	540,699	0		16.00	
17.00	RADIOISOTOPE	56.00	0	79,455	0		17.00	
18.00	CARDIAC CATHETERIZATION	59.00	0	355,092	0		18.00	
19.00	LABORATORY	60.00	0	3,222	0		19.00	
20.00	RESPIRATORY THERAPY	65.00	0	53,384	0		20.00	
21.00	PHYSICAL THERAPY	66.00	0	1,558	0		21.00	
22.00	ELECTROCARDIOLOGY	69.00	0	68,668	0		22.00	
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,023	0		23.00	
24.00	RENAL DIALYSIS	74.00	0	11,916	0		24.00	
25.00	CARDIAC REHABILITATION	76.97	0	1,532	0		25.00	
26.00	CLINIC	90.00	0	3,200	0		26.00	
27.00	EMERGENCY	91.00	0	95,714	0		27.00	
28.00	NONREIMBURSABLE COST CENTERS	194.00	0	5,246	0		28.00	
	TOTALS		0	9,965,657				

RECLASSIFICATIONS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
5/27/2021 8:39 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	E - RECLASS CAFETERIA						
1.00	DIETARY	10.00	0	1,139,327	0		1.00
	TOTALS		0	1,139,327			
	F - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,854,996	0		1.00
	TOTALS		0	4,854,996			
	G - INCENTIVE COMP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	444,000	0	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
10.00		0.00	0	0	0		10.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
	TOTALS		444,000	0			
	H - COVID EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	4,096,373	4,335,879	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
	TOTALS		4,096,373	4,335,879			
500.00	Grand Total: Decreases		4,540,373	41,603,638			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
5/27/2021 8:39 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,847,978	714,843	0	714,843	5,984	1.00
2.00	Land Improvements	4,518,954	4,724,404	0	4,724,404	936,579	2.00
3.00	Buildings and Fixtures	142,782,226	191,027,519	0	191,027,519	6,050,434	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	31,430,646	59,966,098	0	59,966,098	2,956,882	5.00
6.00	Movable Equipment	61,901	114,523	0	114,523	0	6.00
7.00	HIT designated Assets	619,543	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	183,261,248	256,547,387	0	256,547,387	9,949,879	8.00
9.00	Reconciling Items	-3,411,903	-12,664,230	0	-12,664,230	-17,274	9.00
10.00	Total (line 8 minus line 9)	186,673,151	269,211,617	0	269,211,617	9,967,153	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	4,556,837	0				1.00
2.00	Land Improvements	8,306,779	3,555,219				2.00
3.00	Buildings and Fixtures	327,759,311	95,289,444				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	88,439,862	36,205,715				5.00
6.00	Movable Equipment	176,424	48,692				6.00
7.00	HIT designated Assets	619,543	268,849				7.00
8.00	Subtotal (sum of lines 1-7)	429,858,756	135,367,919				8.00
9.00	Reconciling Items	-16,058,859	0				9.00
10.00	Total (line 8 minus line 9)	445,917,615	135,367,919				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
5/27/2021 8:39 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
5/27/2021 8:39 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	NEW CAP REL COSTS-BLDG & FIXT	4	0	4	0.800000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1	0	1	0.200000	0	2.00
3.00	Total (sum of lines 1-2)	5	0	5	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	7,343,408	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,607,734	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,951,142	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	7,343,408	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,607,734	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	10,951,142	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0048

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

Worksheet A-8

Date/Time Prepared:
5/27/2021 8:39 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	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A-8-2		0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00	
3.00	Investment income - other (chapter 2)		0	0.00	0	3.00	
4.00	Trade, quantity, and time discounts (chapter 8)		0	0.00	0	4.00	
5.00	Refunds and rebates of expenses (chapter 8)		0	0.00	0	5.00	
6.00	Rental of provider space by suppliers (chapter 8)		0	0.00	0	6.00	
7.00	Telephone services (pay stations excluded) (chapter 21)		0	0.00	0	7.00	
8.00	Television and radio service (chapter 21)		0	0.00	0	8.00	
9.00	Parking lot (chapter 21)		0	0.00	0	9.00	
10.00	Provider-based physician adjustment				0	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	5,026,946			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-367,946	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0048

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

Worksheet A-8

Date/Time Prepared:
5/27/2021 8:39 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			
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	NONALLOWABLE INTEREST EXPENSE	A	-1,483,120	ADMINISTRATIVE & GENERAL	5.00	0	33.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	MEDICAID ASSESSMENT FROM F/S	A	-8,519,866	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	PBP	A	-20,903	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	ADD MEDICARE DEPRECIATION	A	-136,101	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	42.00
43.00	ADD MEDICARE DEPRECIATION	A	-133,856	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	LOBBYING COSTS	A	-26,417	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.05	PHO EXPENSE	A	-1,032,160	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	HOSPICE	A	-154,575	ADULTS & PEDIATRICS	30.00	0	45.06
45.07	MISC INCOME	B	-205,048	LABORATORY	60.00	0	45.07
45.08	MISC INCOME	B	-163,951	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	MISC INCOME	B	-18,337	ADULTS & PEDIATRICS	30.00	0	45.09
45.10	MISC INCOME	B	-66,633	OPERATION OF PLANT	7.00	0	45.10
45.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.11
45.12	MISC INCOME	B	-249	RADIOISOTOPE	56.00	0	45.12
45.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.13
45.14	MISC INCOME	B	-1,770	RESPIRATORY THERAPY	65.00	0	45.14
45.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.15
45.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.16
45.17	MISC INCOME	B	-7,842	PHYSICAL THERAPY	66.00	0	45.17
45.18	NON ALLOWABLE	A	-25,373	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.18
45.19	NON ALLOWABLE	A	-64,404	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	NON ALLOWABLE	A	-1,280	PHARMACY	15.00	0	45.20
45.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.21
45.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.22
45.23	NON ALLOWABLE	A	-1,357	OPERATING ROOM	50.00	0	45.23
45.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.24
45.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.25
45.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.26
45.27	NON ALLOWABLE	A	-39,415	EMERGENCY	91.00	0	45.27
45.28	NON ALLOWABLE	A	-25,853	NURSING ADMINISTRATION	13.00	0	45.28
45.29	NON ALLOWABLE	A	-5,439	PHYSICAL THERAPY	66.00	0	45.29
45.30	NON ALLOWABLE	A	-13,135	NONREIMBURSABLE COST CENTERS	194.00	0	45.30
45.31	NON ALLOWABLE	A	-3,190	ELECTROCARDIOLOGY	69.00	0	45.31
45.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.45
45.46	NON ALLOWABLE	A	-3,199	ADULTS & PEDIATRICS	30.00	0	45.46
45.47	NON ALLOWABLE	A	-2,441	INTENSIVE CARE UNIT	31.00	0	45.47
45.48	NON ALLOWABLE	A	-311	RADIOLOGY-DIAGNOSTIC	54.00	0	45.48
45.49	NON ALLOWABLE	A	-6,252	RESPIRATORY THERAPY	65.00	0	45.49
45.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.50
46.00	PATIENT TRANSPORT	A	-15,253	EMERGENCY	91.00	0	46.00
46.01	PATIENT TRANSPORT	A	-10,995	NURSING ADMINISTRATION	13.00	0	46.01
46.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0048

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

Worksheet A-8

Date/Time Prepared:
5/27/2021 8:39 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	
46.03	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.03
46.04	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.04
46.05	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.05
46.06	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.06
46.07	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.07
46.08	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.08
46.09	OTHER ADJUSTMENTS (SPECIFY (3)		0		0.00	0	46.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,131,826				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: 14-0048

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2021 8:39 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 PERSONNEL	2,504,369	0	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL DATA PROCESSING	9,527,677	0	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL ADMIN & GENERAL	4,511,092	12,771,634	3.00
4.00		1.00	NEW CAP REL COSTS-BLDG & FIX DEPRECIATION	204,802	0	4.00
4.01		2.00	NEW CAP REL COSTS-MVBLE EQUI DEPRECIATION	1,050,640	0	4.01
4.02		0.00		0	0	4.02
4.03		0.00		0	0	4.03
5.00	0		0	17,798,580	12,771,634	5.00

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

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

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

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

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

6.00	B	TRINITY HOSPITA	100.00	ADVOCATE HEALTHCARE	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: 14-0048

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2021 8:39 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	2,504,369	0		1.00
2.00	9,527,677	0		2.00
3.00	-8,260,542	0		3.00
4.00	204,802	9		4.00
4.01	1,050,640	9		4.01
4.02	0	0		4.02
4.03	0	0		4.03
5.00	5,026,946			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0048

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2021 8:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,330,307	2,330,307	0	0	1	1.00
2.00	59.00	CARDIAC CATHETERIZATION	748,827	748,827	0	0	1	2.00
3.00	53.00	ANESTHESIOLOGY	2,454,067	2,454,067	0	0	1	3.00
4.00	66.00	PHYSICAL THERAPY	18,900	18,900	0	0	1	4.00
5.00	43.00	NURSERY	50,000	50,000	0	0	1	5.00
6.00	0.00		0	0	0	0	1	6.00
7.00	0.00		0	0	0	0	1	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			5,602,101	5,602,101	0	0	7	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	4.00
5.00	43.00	NURSERY	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	30.00	ADULTS & PEDIATRICS	0	0	0	2,330,307		1.00
2.00	59.00	CARDIAC CATHETERIZATION	0	0	0	748,827		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	2,454,067		3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	18,900		4.00
5.00	43.00	NURSERY	0	0	0	50,000		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,602,101		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	7,343,408	7,343,408			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,607,734	3,607,734			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,710,389	72,460	35,599	13,818,448	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,769,238	810,585	398,231	846,693	5.00
7.00	00700	OPERATION OF PLANT	8,555,430	1,241,579	609,974	34	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	706,671	43,578	21,409	0	8.00
9.00	00900	HOUSEKEEPING	2,517,329	117,280	57,618	0	9.00
10.00	01000	DIETARY	1,894,135	196,213	96,397	0	10.00
11.00	01100	CAFETERIA	771,381	120,427	59,165	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,643,505	159,927	78,570	1,153,978	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	3,963,721	97,530	47,915	681,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,495	7,137	3,507	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,464,420	1,615,072	793,468	4,306,606	30.00
31.00	03100	INTENSIVE CARE UNIT	7,353,536	517,064	254,028	1,297,583	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	769,039	47,923	23,544	165,550	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,944,118	762,463	374,589	951,188	50.00
51.00	05100	RECOVERY ROOM	711,202	18,775	9,224	153,195	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	59,902	731	359	12,671	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,501,812	334,417	164,295	916,433	54.00
56.00	05600	RADIOISOTOPE	407,109	50,361	24,742	89,878	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,155,119	101,919	50,072	248,942	59.00
60.00	06000	LABORATORY	7,587,053	173,116	85,050	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,759,412	57,942	28,466	345,946	65.00
66.00	06600	PHYSICAL THERAPY	1,938,895	148,334	72,875	351,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,297,687	67,362	33,094	263,201	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	59,215	4,455	2,189	12,535	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,736,334	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,854,996	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,799,202	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,159,483	49,031	24,088	246,813	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	268,364	61,932	30,426	57,525	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	1,102,340	57,188	28,096	180,406	90.00
91.00	09100	EMERGENCY	7,730,570	379,791	186,587	1,501,153	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,250,244	7,314,592	3,593,577	13,783,273	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	NONREIM PARAME RT	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	252,610	28,816	14,157	35,175	194.00
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	168,502,854	7,343,408	3,607,734	13,818,448	168,502,854	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,824,747					5.00
7.00	00700	OPERATION OF PLANT	2,910,395	13,317,412				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	215,800	111,204	1,098,662			8.00
9.00	00900	HOUSEKEEPING	752,900	299,277	0	3,744,404		9.00
10.00	01000	DIETARY	611,539	500,700	0	145,257	3,444,241	10.00
11.00	01100	CAFETERIA	265,946	307,309	0	89,153	1,408,646	11.00
13.00	01300	NURSING ADMINISTRATION	1,967,661	408,105	0	118,395	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,339,612	248,879	0	72,202	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,038	18,213	0	5,284	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,600,999	4,121,383	404,101	1,195,646	1,615,890	30.00
31.00	03100	INTENSIVE CARE UNIT	2,634,987	1,319,456	106,026	382,785	419,705	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	281,351	122,290	0	35,477	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,966,648	1,945,670	120,271	564,454	0	50.00
51.00	05100	RECOVERY ROOM	249,565	47,909	4,093	13,899	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,600	1,867	0	542	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,654,718	853,373	204,813	247,570	0	54.00
56.00	05600	RADIOISOTOPE	159,989	128,512	0	37,282	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	435,161	260,079	24,881	75,451	0	59.00
60.00	06000	LABORATORY	2,193,970	441,761	0	128,158	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	612,943	147,857	0	42,894	0	65.00
66.00	06600	PHYSICAL THERAPY	702,503	378,523	11,007	109,812	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	464,606	171,896	0	49,869	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,923	11,369	0	3,298	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,443,177	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,357,734	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,181,101	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	413,729	125,118	12,533	36,298	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	116,966	158,038	2,688	45,848	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	382,579	145,934	0	42,337	0	90.00
91.00	09100	EMERGENCY	2,740,108	969,158	208,249	281,161	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,732,248	13,243,880	1,098,662	3,723,072	3,444,241	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	92,499	73,532	0	21,332	0	194.00
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)	36,824,747	13,317,412	1,098,662	3,744,404	3,444,241	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,022,027					11.00
13.00	01300	NURSING ADMINISTRATION	268,843	9,798,984				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	158,660	0	0	6,609,549		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	174,674	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,003,310	4,797,463	0	167,530	74,920	30.00
31.00	03100	INTENSIVE CARE UNIT	302,299	996,648	0	77,629	345	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	38,568	184,855	0	581	6,625	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	221,599	1,084,994	0	14,035	30,424	50.00
51.00	05100	RECOVERY ROOM	35,690	123,938	0	1,837	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,952	18,507	0	11,587	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	213,502	131,750	0	34,466	20,468	54.00
56.00	05600	RADIOISOTOPE	20,939	13,907	0	51,447	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	57,996	45,534	0	11,549	0	59.00
60.00	06000	LABORATORY	0	0	0	490	4,078	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	80,595	81,697	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	81,985	52,317	0	0	191	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	61,318	95,354	0	1,942	1,666	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,920	13,961	0	0	134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,997	0	5,963,988	0	73.00
74.00	07400	RENAL DIALYSIS	57,500	247,920	0	7,579	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,402	18,247	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	42,029	111,275	0	7,168	287	90.00
91.00	09100	EMERGENCY	349,725	1,753,090	0	257,712	33,621	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,013,832	9,797,454	0	6,609,540	172,759	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	8,195	1,530	0	9	1,915	194.00
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)	3,022,027	9,798,984	0	6,609,549	174,674	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
				SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS			
			17.00	21.00	22.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		0			22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	48,160,808	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	15,662,091	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,675,803	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	12,980,453	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,369,327	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	129,718	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,277,617	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	984,166	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,466,703	0	59.00
60.00	06000	LABORATORY	0	0	0	10,613,676	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,157,752	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,848,355	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,507,995	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	131,999	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,179,511	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,212,730	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,970,288	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,380,092	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	773,436	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	2,099,639	0	90.00
91.00	09100	EMERGENCY	0	0	0	16,390,925	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	167,973,084	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	0	0	529,770	0	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
				SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS			
			17.00	21.00	22.00	24.00	25.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	168,502,854	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03140	CARDIOLOGY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	NONREIM PARAMED RT	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	194.00
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: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	72,460	35,599	108,059	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	810,585	398,231	1,208,816	5.00
7.00	00700	OPERATION OF PLANT	0	1,241,579	609,974	1,851,553	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,578	21,409	64,987	8.00
9.00	00900	HOUSEKEEPING	0	117,280	57,618	174,898	9.00
10.00	01000	DIETARY	0	196,213	96,397	292,610	10.00
11.00	01100	CAFETERIA	0	120,427	59,165	179,592	11.00
13.00	01300	NURSING ADMINISTRATION	0	159,927	78,570	238,497	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	97,530	47,915	145,445	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,137	3,507	10,644	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,615,072	793,468	2,408,540	30.00
31.00	03100	INTENSIVE CARE UNIT	0	517,064	254,028	771,092	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	47,923	23,544	71,467	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	762,463	374,589	1,137,052	50.00
51.00	05100	RECOVERY ROOM	0	18,775	9,224	27,999	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	731	359	1,090	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	334,417	164,295	498,712	54.00
56.00	05600	RADIOISOTOPE	0	50,361	24,742	75,103	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	101,919	50,072	151,991	59.00
60.00	06000	LABORATORY	0	173,116	85,050	258,166	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	57,942	28,466	86,408	65.00
66.00	06600	PHYSICAL THERAPY	0	148,334	72,875	221,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	67,362	33,094	100,456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,455	2,189	6,644	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	49,031	24,088	73,119	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	61,932	30,426	92,358	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	57,188	28,096	85,284	90.00
91.00	09100	EMERGENCY	0	379,791	186,587	566,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,314,592	3,593,577	10,908,169	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	28,816	14,157	42,973	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
			1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	0	7,343,408	3,607,734	10,951,142	108,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,215,436					5.00
7.00	00700	OPERATION OF PLANT	96,057	1,947,610				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,122	16,263	88,372			8.00
9.00	00900	HOUSEKEEPING	24,849	43,768	0	243,515		9.00
10.00	01000	DIETARY	20,184	73,225	0	9,447	395,466	10.00
11.00	01100	CAFETERIA	8,777	44,943	0	5,798	161,740	11.00
13.00	01300	NURSING ADMINISTRATION	64,942	59,684	0	7,700	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	44,214	36,397	0	4,696	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,090	2,664	0	344	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	250,915	602,734	32,506	77,755	185,536	30.00
31.00	03100	INTENSIVE CARE UNIT	86,967	192,964	8,528	24,894	48,190	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,286	17,884	0	2,307	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64,909	284,545	9,674	36,709	0	50.00
51.00	05100	RECOVERY ROOM	8,237	7,007	329	904	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	680	273	0	35	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,614	124,802	16,474	16,101	0	54.00
56.00	05600	RADIOISOTOPE	5,280	18,794	0	2,425	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,362	38,035	2,001	4,907	0	59.00
60.00	06000	LABORATORY	72,411	64,605	0	8,335	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	20,230	21,623	0	2,790	0	65.00
66.00	06600	PHYSICAL THERAPY	23,186	55,357	885	7,142	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,334	25,139	0	3,243	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	724	1,663	0	215	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,636	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	44,812	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,987	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13,655	18,298	1,008	2,361	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,860	23,112	216	2,982	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	12,627	21,342	0	2,753	0	90.00
91.00	09100	EMERGENCY	90,436	141,735	16,751	18,285	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,212,383	1,936,856	88,372	242,128	395,466	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	3,053	10,754	0	1,387	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,215,436	1,947,610	88,372	243,515	395,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	400,850					11.00
13.00	01300	NURSING ADMINISTRATION	35,660	415,506				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	21,045	0	0	257,122		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	14,742	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	133,084	203,427	0	6,517	6,323	30.00
31.00	03100	INTENSIVE CARE UNIT	40,097	42,261	0	3,020	29	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,116	7,838	0	23	559	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,393	46,007	0	546	2,568	50.00
51.00	05100	RECOVERY ROOM	4,734	5,255	0	71	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	392	785	0	451	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,319	5,587	0	1,341	1,727	54.00
56.00	05600	RADIOISOTOPE	2,777	590	0	2,001	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,693	1,931	0	449	0	59.00
60.00	06000	LABORATORY	0	0	0	19	344	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	10,690	3,464	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,875	2,218	0	0	16	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,133	4,043	0	76	141	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	387	592	0	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,102	0	232,009	0	73.00
74.00	07400	RENAL DIALYSIS	7,627	10,513	0	295	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,778	774	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	5,575	4,718	0	279	24	90.00
91.00	09100	EMERGENCY	46,388	74,336	0	10,025	2,838	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	399,763	415,441	0	257,122	14,580	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	1,087	65	0	0	162	194.00
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)	400,850	415,506	0	257,122	14,742	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
				SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS			
			17.00	21.00	22.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		0			22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0			3,941,021	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0			1,228,188	0	31.00
32.00	03200	CORONARY CARE UNIT	0			0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0			0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0			0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0			0	0	41.00
42.00	04200	SUBPROVIDER	0			0	0	42.00
43.00	04300	NURSERY	0			115,774	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0			1,618,840	0	50.00
51.00	05100	RECOVERY ROOM	0			55,734	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53.00	05300	ANESTHESIOLOGY	0			3,805	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0			754,843	0	54.00
56.00	05600	RADIOISOTOPE	0			107,673	0	56.00
57.00	05700	CT SCAN	0			0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0			223,316	0	59.00
60.00	06000	LABORATORY	0			403,880	0	60.00
60.01	06001	BLOOD LABORATORY	0			0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0			147,910	0	65.00
66.00	06600	PHYSICAL THERAPY	0			323,640	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0			0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0			0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0			158,623	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			10,334	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			80,636	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0			44,812	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0			305,098	0	73.00
74.00	07400	RENAL DIALYSIS	0			128,806	0	74.00
76.00	03140	CARDIOLOGY	0			0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0			125,530	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0			0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89.00
90.00	09000	CLINIC	0			134,013	0	90.00
91.00	09100	EMERGENCY	0			978,910	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	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0			0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0			0	0	110.00
111.00	11100	ISLET ACQUISITION	0			0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	10,891,386	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0			0	0	192.00
192.01	19201	NONREIM PARAMED RT	0			0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0			59,756	0	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SOCIAL SERVICE	SERVICES-SALA RY & FRINGES			
			17.00	21.00	22.00	24.00	25.00
201.00	Negative Cost Centers		0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)		0	0	0	10,951,142	0

201.00
202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03140	CARDIOLOGY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	NONREIM PARAMED RT	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	194.00
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: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQ. FEET OLD)	NEW MVBLE EQUIP (SQ. FEET OLD)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	331,293					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		331,293				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,269	3,269	56,987,641			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,569	36,569	3,491,793	-36,824,747	131,678,107	5.00
7.00	00700	OPERATION OF PLANT	56,013	56,013	140	0	10,407,017	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,966	1,966	0	0	771,658	8.00
9.00	00900	HOUSEKEEPING	5,291	5,291	0	0	2,692,227	9.00
10.00	01000	DIETARY	8,852	8,852	0	0	2,186,745	10.00
11.00	01100	CAFETERIA	5,433	5,433	0	0	950,973	11.00
13.00	01300	NURSING ADMINISTRATION	7,215	7,215	4,759,044	0	7,035,980	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,400	4,400	2,808,592	0	4,790,196	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	322	322	0	0	118,139	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	72,863	72,863	17,760,483	0	27,179,566	30.00
31.00	03100	INTENSIVE CARE UNIT	23,327	23,327	5,351,279	0	9,422,211	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,162	2,162	682,732	0	1,006,056	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,398	34,398	3,922,731	0	7,032,358	50.00
51.00	05100	RECOVERY ROOM	847	847	631,780	0	892,396	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33	33	52,254	0	73,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,087	15,087	3,779,400	0	5,916,957	54.00
56.00	05600	RADIOISOTOPE	2,272	2,272	370,661	0	572,090	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,598	4,598	1,026,645	0	1,556,052	59.00
60.00	06000	LABORATORY	7,810	7,810	0	0	7,845,219	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,614	2,614	1,426,695	0	2,191,766	65.00
66.00	06600	PHYSICAL THERAPY	6,692	6,692	1,451,301	0	2,512,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,039	3,039	1,085,449	0	1,661,344	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	201	201	51,693	0	78,394	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,736,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,854,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,799,202	73.00
74.00	07400	RENAL DIALYSIS	2,212	2,212	1,017,867	0	1,479,415	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,794	2,794	237,235	0	418,247	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,580	2,580	743,999	0	1,368,030	90.00
91.00	09100	EMERGENCY	17,134	17,134	6,190,805	0	9,798,101	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	329,993	329,993	56,842,578	-36,824,747	131,347,349	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	1,300	1,300	145,063	0	330,758	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQ. FEET OLD)	NEW MVBLE EQUIP (SQ. FEET OLD)				
			1.00	2.00	4.00	5A	5.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,343,408	3,607,734	13,818,448		36,824,747	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.165901	10.889859	0.242481		0.279657	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			108,059		1,215,436	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001896		0.009230	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: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		OPERATION OF PLANT (SQ. FEET OLD)	LAUNDRY & LINEN SERVICE (LAUNDRY LBS)	HOUSEKEEPING (SQ. FEET OLD)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	235,442				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,966	889,522			8.00
9.00	00900	HOUSEKEEPING	5,291	0	228,185		9.00
10.00	01000	DIETARY	8,852	0	8,852	195,442	10.00
11.00	01100	CAFETERIA	5,433	0	5,433	79,933	53,495,708
13.00	01300	NURSING ADMINISTRATION	7,215	0	7,215	0	4,759,044
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	4,400	0	4,400	0	2,808,592
16.00	01600	MEDICAL RECORDS & LIBRARY	322	0	322	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	72,863	327,177	72,863	91,693	17,760,483
31.00	03100	INTENSIVE CARE UNIT	23,327	85,843	23,327	23,816	5,351,279
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	2,162	0	2,162	0	682,732
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,398	97,376	34,398	0	3,922,731
51.00	05100	RECOVERY ROOM	847	3,314	847	0	631,780
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	33	0	33	0	52,254
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,087	165,825	15,087	0	3,779,400
56.00	05600	RADIOISOTOPE	2,272	0	2,272	0	370,661
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	4,598	20,145	4,598	0	1,026,645
60.00	06000	LABORATORY	7,810	0	7,810	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,614	0	2,614	0	1,426,695
66.00	06600	PHYSICAL THERAPY	6,692	8,912	6,692	0	1,451,301
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,039	0	3,039	0	1,085,449
70.00	07000	ELECTROENCEPHALOGRAPHY	201	0	201	0	51,693
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	2,212	10,147	2,212	0	1,017,867
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	2,794	2,176	2,794	0	237,235
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	2,580	0	2,580	0	743,999
91.00	09100	EMERGENCY	17,134	168,607	17,134	0	6,190,805
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,142	889,522	226,885	195,442	53,350,645
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0
194.00	07951	NONREIMBURSABLE COST CENTERS	1,300	0	1,300	0	145,063
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	13,317,412	1,098,662	3,744,404	3,444,241	3,022,027

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		OPERATION OF PLANT (SQ. FEET OLD)	LAUNDRY & LINEN SERVICE (LAUNDRY LBS)	HOUSEKEEPING (SQ. FEET OLD)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	56.563451	1.235115	16.409510	17.622829	0.056491	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,947,610	88,372	243,515	395,466	400,850	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	8.272143	0.099348	1.067182	2.023444	0.007493	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: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			NURSING ADMINISTRATION (NSG FTE)	CENTRAL SERVICES & SUPPLY (MED SUPPL COSTS)	PHARMACY (PHARM COSTS)	MEDICAL RECORDS & LIBRARY (MED REC TIME)	SOCIAL SERVICE (SOC SERV TIME)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,094,954					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	7,706,742			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9,123		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	536,076	0	195,340	3,913	0	30.00
31.00	03100	INTENSIVE CARE UNIT	111,367	0	90,516	18	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	20,656	0	678	346	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	121,239	0	16,365	1,589	0	50.00
51.00	05100	RECOVERY ROOM	13,849	0	2,142	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,068	0	13,510	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,722	0	40,187	1,069	0	54.00
56.00	05600	RADIOISOTOPE	1,554	0	59,987	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,088	0	13,466	0	0	59.00
60.00	06000	LABORATORY	0	0	571	213	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	9,129	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,846	0	0	10	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,655	0	2,264	87	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,560	0	0	7	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,905	0	6,954,018	0	0	73.00
74.00	07400	RENAL DIALYSIS	27,703	0	8,837	0	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,039	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	12,434	0	8,358	15	0	90.00
91.00	09100	EMERGENCY	195,893	0	300,492	1,756	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								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,094,783	0	7,706,731	9,023	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	171	0	11	100	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		NURSING ADMINISTRATIO N (NSG FTE)	CENTRAL SERVICES & SUPPLY (MED SUPPL COSTS)	PHARMACY (PHARM COSTS)	MEDICAL RECORDS & LIBRARY (MED REC TIME)	SOCIAL SERVICE (SOC SERV TIME)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	9,798,984	0	6,609,549	174,674	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.949220	0.000000	0.857632	19.146553	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	415,506	0	257,122	14,742	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.379473	0.000000	0.033363	1.615916	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: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			INTERNS & RESIDENTS			
			SERVICES-SALA	SERVICES-OTHE		
			RY & FRINGES	R PRGM COSTS		
(HRS)	(HRS)					
			21.00	22.00		
	GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
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					
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	NONREIM PARAMED RT	0	0		192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES (HRS)	SERVICES-OTHER PRGM COSTS (HRS)		
		21.00	22.00		
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)				206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/27/2021 8:39 am

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,160,808	48,160,808	0	48,160,808 30.00
31.00	03100	INTENSIVE CARE UNIT	15,662,091	15,662,091	0	15,662,091 31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0 34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0 42.00
43.00	04300	NURSERY	1,675,803	1,675,803	0	1,675,803 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,980,453	12,980,453	0	12,980,453 50.00
51.00	05100	RECOVERY ROOM	1,369,327	1,369,327	0	1,369,327 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	129,718	129,718	0	129,718 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,277,617	9,277,617	0	9,277,617 54.00
56.00	05600	RADIOISOTOPE	984,166	984,166	0	984,166 56.00
57.00	05700	CT SCAN	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,466,703	2,466,703	0	2,466,703 59.00
60.00	06000	LABORATORY	10,613,676	10,613,676	0	10,613,676 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	3,157,752	3,157,752	0	3,157,752 65.00
66.00	06600	PHYSICAL THERAPY	3,848,355	3,848,355	0	3,848,355 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	2,507,995	2,507,995	0	2,507,995 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	131,999	131,999	0	131,999 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,179,511	11,179,511	0	11,179,511 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,212,730	6,212,730	0	6,212,730 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,970,288	15,970,288	0	15,970,288 73.00
74.00	07400	RENAL DIALYSIS	2,380,092	2,380,092	0	2,380,092 74.00
76.00	03140	CARDIOLOGY	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	773,436	773,436	0	773,436 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0 89.00
90.00	09000	CLINIC	2,099,639	2,099,639	0	2,099,639 90.00
91.00	09100	EMERGENCY	16,390,925	16,390,925	0	16,390,925 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,991,876	9,991,876	0	9,991,876 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0 111.00
200.00		Subtotal (see instructions)	177,964,960	177,964,960	0	177,964,960 200.00
201.00		Less Observation Beds	9,991,876	9,991,876	0	9,991,876 201.00
202.00		Total (see instructions)	167,973,084	167,973,084	0	167,973,084 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,425,661		65,425,661		30.00
31.00	03100	INTENSIVE CARE UNIT	24,977,828		24,977,828		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,289,180		2,289,180		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,963,710	30,392,053	40,355,763	0.321651	50.00
51.00	05100	RECOVERY ROOM	1,714,078	4,740,192	6,454,270	0.212158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,172,728	5,965,176	8,137,904	0.015940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,944,561	59,255,677	90,200,238	0.102856	54.00
56.00	05600	RADIOISOTOPE	2,935,022	4,674,577	7,609,599	0.129332	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,676,866	4,284,657	13,961,523	0.176679	59.00
60.00	06000	LABORATORY	34,679,173	23,520,007	58,199,180	0.182368	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	13,538,833	2,245,805	15,784,638	0.200052	65.00
66.00	06600	PHYSICAL THERAPY	5,449,624	4,624,552	10,074,176	0.382002	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,333,042	9,274,904	17,607,946	0.142435	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	405,670	150,588	556,258	0.237298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,756,705	4,218,028	8,974,733	1.245665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,110,837	7,981,023	13,091,860	0.474549	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,468,052	25,887,597	74,355,649	0.214782	73.00
74.00	07400	RENAL DIALYSIS	4,185,371	0	4,185,371	0.568669	74.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	23,604	785,717	809,321	0.955660	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	3,878,375	3,878,375	0.541371	90.00
91.00	09100	EMERGENCY	26,548,407	72,141,981	98,690,388	0.166084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,326,118	12,246,876	18,572,994	0.537979	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	307,925,070	276,267,785	584,192,855		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	307,925,070	276,267,785	584,192,855		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.321651			50.00
51.00	05100	RECOVERY ROOM	0.212158			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.015940			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102856			54.00
56.00	05600	RADIOISOTOPE	0.129332			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176679			59.00
60.00	06000	LABORATORY	0.182368			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.200052			65.00
66.00	06600	PHYSICAL THERAPY	0.382002			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.142435			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237298			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245665			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.474549			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214782			73.00
74.00	07400	RENAL DIALYSIS	0.568669			74.00
76.00	03140	CARDIOLOGY	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.955660			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.541371			90.00
91.00	09100	EMERGENCY	0.166084			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537979			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/27/2021 8:39 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	48,160,808		48,160,808	0	48,160,808	30.00	
31.00	03100	INTENSIVE CARE UNIT	15,662,091		15,662,091	0	15,662,091	31.00	
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
42.00	04200	SUBPROVIDER	0		0	0	0	42.00	
43.00	04300	NURSERY	1,675,803		1,675,803	0	1,675,803	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	12,980,453		12,980,453	0	12,980,453	50.00	
51.00	05100	RECOVERY ROOM	1,369,327		1,369,327	0	1,369,327	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	129,718		129,718	0	129,718	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,277,617		9,277,617	0	9,277,617	54.00	
56.00	05600	RADIOISOTOPE	984,166		984,166	0	984,166	56.00	
57.00	05700	CT SCAN	0		0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	2,466,703		2,466,703	0	2,466,703	59.00	
60.00	06000	LABORATORY	10,613,676		10,613,676	0	10,613,676	60.00	
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	3,157,752	0	3,157,752	0	3,157,752	65.00	
66.00	06600	PHYSICAL THERAPY	3,848,355	0	3,848,355	0	3,848,355	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	2,507,995		2,507,995	0	2,507,995	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	131,999		131,999	0	131,999	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,179,511		11,179,511	0	11,179,511	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,212,730		6,212,730	0	6,212,730	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	15,970,288		15,970,288	0	15,970,288	73.00	
74.00	07400	RENAL DIALYSIS	2,380,092		2,380,092	0	2,380,092	74.00	
76.00	03140	CARDIOLOGY	0		0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	773,436		773,436	0	773,436	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00	
90.00	09000	CLINIC	2,099,639		2,099,639	0	2,099,639	90.00	
91.00	09100	EMERGENCY	16,390,925		16,390,925	0	16,390,925	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,991,876		9,991,876	0	9,991,876	92.00	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	99.10	
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00	
111.00	11100	ISLET ACQUISITION	0		0		0	111.00	
200.00		Subtotal (see instructions)	177,964,960	0	177,964,960	0	177,964,960	200.00	
201.00		Less Observation Beds	9,991,876		9,991,876		9,991,876	201.00	
202.00		Total (see instructions)	167,973,084	0	167,973,084	0	167,973,084	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/27/2021 8:39 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,425,661		65,425,661		30.00
31.00	03100	INTENSIVE CARE UNIT	24,977,828		24,977,828		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,289,180		2,289,180		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,963,710	30,392,053	40,355,763	0.321651	50.00
51.00	05100	RECOVERY ROOM	1,714,078	4,740,192	6,454,270	0.212158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,172,728	5,965,176	8,137,904	0.015940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,944,561	59,255,677	90,200,238	0.102856	54.00
56.00	05600	RADIOISOTOPE	2,935,022	4,674,577	7,609,599	0.129332	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,676,866	4,284,657	13,961,523	0.176679	59.00
60.00	06000	LABORATORY	34,679,173	23,520,007	58,199,180	0.182368	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	13,538,833	2,245,805	15,784,638	0.200052	65.00
66.00	06600	PHYSICAL THERAPY	5,449,624	4,624,552	10,074,176	0.382002	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,333,042	9,274,904	17,607,946	0.142435	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	405,670	150,588	556,258	0.237298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,756,705	4,218,028	8,974,733	1.245665	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,110,837	7,981,023	13,091,860	0.474549	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,468,052	25,887,597	74,355,649	0.214782	73.00
74.00	07400	RENAL DIALYSIS	4,185,371	0	4,185,371	0.568669	74.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	23,604	785,717	809,321	0.955660	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	3,878,375	3,878,375	0.541371	90.00
91.00	09100	EMERGENCY	26,548,407	72,141,981	98,690,388	0.166084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,326,118	12,246,876	18,572,994	0.537979	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	307,925,070	276,267,785	584,192,855		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	307,925,070	276,267,785	584,192,855		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/27/2021 8:39 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
32.00	03200	CORONARY CARE UNIT				32.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03140	CARDIOLOGY	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
5/27/2021 8:39 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,941,021	0	3,941,021	31,648	124.53	30.00
31.00	INTENSIVE CARE UNIT	1,228,188		1,228,188	6,489	189.27	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	115,774		115,774	433	267.38	43.00
200.00	Total (lines 30 through 199)	5,284,983		5,284,983	38,570		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,281	782,173				
31.00	INTENSIVE CARE UNIT	1,404	265,735				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	7,685	1,047,908				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 5/27/2021 8:39 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		1,618,840	40,355,763	0.040114	2,013,481	80,769	50.00
51.00	05100	RECOVERY ROOM		55,734	6,454,270	0.008635	309,304	2,671	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY		3,805	8,137,904	0.000468	344,925	161	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		754,843	90,200,238	0.008369	7,690,260	64,360	54.00
56.00	05600	RADIOISOTOPE		107,673	7,609,599	0.014150	759,834	10,752	56.00
57.00	05700	CT SCAN		0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		223,316	13,961,523	0.015995	2,241,707	35,856	59.00
60.00	06000	LABORATORY		403,880	58,199,180	0.006940	7,780,940	54,000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY		147,910	15,784,638	0.009371	3,638,064	34,092	65.00
66.00	06600	PHYSICAL THERAPY		323,640	10,074,176	0.032126	1,632,811	52,456	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		158,623	17,607,946	0.009009	2,065,685	18,610	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		10,334	556,258	0.018578	99,122	1,841	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		80,636	8,974,733	0.008985	1,117,486	10,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		44,812	13,091,860	0.003423	1,252,042	4,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		305,098	74,355,649	0.004103	11,742,662	48,180	73.00
74.00	07400	RENAL DIALYSIS		128,806	4,185,371	0.030775	1,485,995	45,731	74.00
76.00	03140	CARDIOLOGY		0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		125,530	809,321	0.155105	1,867	290	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0.000000	0	0	89.00
90.00	09000	CLINIC		134,013	3,878,375	0.034554	0	0	90.00
91.00	09100	EMERGENCY		978,910	98,690,388	0.009919	5,932,354	58,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		817,635	18,572,994	0.044023	1,616,032	71,143	92.00
200.00		Total (lines 50 through 199)		6,424,038	491,500,186		51,724,571	594,082	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part III
Date/Time Prepared:
5/27/2021 8:39 am

				Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	31,648	0.00	6,281		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	6,489	0.00	1,404		31.00	
32.00	03200	CORONARY CARE UNIT		0	0	0.00	0		32.00	
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0		33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0		34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0		41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0		42.00	
43.00	04300	NURSERY		0	433	0.00	0		43.00	
200.00		Total (lines 30 through 199)		0	38,570		7,685		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
32.00	03200	CORONARY CARE UNIT	0							32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0							33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0							34.00
41.00	04100	SUBPROVIDER - IRF	0							41.00
42.00	04200	SUBPROVIDER	0							42.00
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/27/2021 8:39 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	40,355,763	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	6,454,270	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	8,137,904	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	90,200,238	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	7,609,599	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	13,961,523	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	58,199,180	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY		0	0	0	15,784,638	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	10,074,176	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
69.00	06900	ELECTROCARDIOLOGY		0	0	0	17,607,946	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	556,258	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	8,974,733	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	13,091,860	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	74,355,649	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	4,185,371	0.000000	74.00
76.00	03140	CARDIOLOGY		0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	809,321	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	3,878,375	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	98,690,388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	18,572,994	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	491,500,186		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/27/2021 8:39 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	2,013,481	0	3,396,482	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	309,304	0	475,808	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	344,925	0	627,196	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	7,690,260	0	6,632,891	0	54.00
56.00	05600	RADIOISOTOPE		0.000000	759,834	0	755,284	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	2,241,707	0	945,694	0	59.00
60.00	06000	LABORATORY		0.000000	7,780,940	0	2,039,227	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY		0.000000	3,638,064	0	315,936	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,632,811	0	87,746	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	2,065,685	0	1,241,490	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	99,122	0	61,149	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	1,117,486	0	671,772	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.000000	1,252,042	0	1,156,587	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	11,742,662	0	3,211,304	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	1,485,995	0	0	0	74.00
76.00	03140	CARDIOLOGY		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	1,867	0	108,117	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	0	0	89.00
90.00	09000	CLINIC		0.000000	0	0	1,370,728	0	90.00
91.00	09100	EMERGENCY		0.000000	5,932,354	0	5,589,546	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	1,616,032	0	2,915,449	0	92.00
200.00		Total (lines 50 through 199)			51,724,571	0	31,602,406	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/27/2021 8:39 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.321651	3,396,482	0	0	1,092,482	50.00
51.00	05100	RECOVERY ROOM	0.212158	475,808	0	0	100,946	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015940	627,196	0	0	9,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102856	6,632,891	0	0	682,233	54.00
56.00	05600	RADIOISOTOPE	0.129332	755,284	0	0	97,682	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176679	945,694	0	0	167,084	59.00
60.00	06000	LABORATORY	0.182368	2,039,227	0	0	371,890	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.200052	315,936	0	0	63,204	65.00
66.00	06600	PHYSICAL THERAPY	0.382002	87,746	0	0	33,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.142435	1,241,490	0	0	176,832	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237298	61,149	0	0	14,511	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245665	671,772	0	0	836,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.474549	1,156,587	0	0	548,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214782	3,211,304	0	26,525	689,730	73.00
74.00	07400	RENAL DIALYSIS	0.568669	0	0	0	0	74.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.955660	108,117	0	0	103,323	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.541371	1,370,728	0	0	742,072	90.00
91.00	09100	EMERGENCY	0.166084	5,589,546	0	0	928,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537979	2,915,449	0	0	1,568,450	92.00
200.00		Subtotal (see instructions)		31,602,406	0	26,525	8,227,950	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		31,602,406	0	26,525	8,227,950	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/27/2021 8:39 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,697		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	5,697		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	5,697		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/27/2021 8:39 am

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.321651	0	0	348,814	0	50.00
51.00	05100	RECOVERY ROOM	0.212158	0	0	58,063	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015940	0	0	55,803	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102856	0	0	1,896,326	0	54.00
56.00	05600	RADIOISOTOPE	0.129332	0	0	118,593	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176679	0	0	58,751	0	59.00
60.00	06000	LABORATORY	0.182368	0	0	1,039,295	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.200052	0	0	65,622	0	65.00
66.00	06600	PHYSICAL THERAPY	0.382002	0	0	94,060	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.142435	0	0	319,017	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237298	0	0	5,228	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245665	0	0	37,694	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.474549	0	0	129,714	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214782	0	0	1,181,846	0	73.00
74.00	07400	RENAL DIALYSIS	0.568669	0	0	0	0	74.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.955660	0	0	11,414	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.541371	0	0	43,430	0	90.00
91.00	09100	EMERGENCY	0.166084	0	0	3,586,838	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537979	0	0	666,517	0	92.00
200.00		Subtotal (see instructions)		0	0	9,717,025	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	9,717,025	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/27/2021 8:39 am

			Title XIX		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	0	112,196		50.00
51.00	05100	RECOVERY ROOM	0	12,319		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	889		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	195,049		54.00
56.00	05600	RADIOISOTOPE	0	15,338		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,380		59.00
60.00	06000	LABORATORY	0	189,534		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	13,128		65.00
66.00	06600	PHYSICAL THERAPY	0	35,931		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	45,439		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,241		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,954		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	61,556		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	253,839		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	10,908		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	23,512		90.00
91.00	09100	EMERGENCY	0	595,716		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	358,572		92.00
200.00		Subtotal (see instructions)	0	1,982,501		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,982,501		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/27/2021 8:39 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		31,648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31,648	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)		25,082	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,281	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		48,160,808	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)		48,160,808	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)		48,160,808	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)		1,521.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,558,175	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,558,175	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0048

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

Worksheet D-1

Date/Time Prepared:
5/27/2021 8:39 am

			Title XVIII		Hospital	PPS			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
			1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)			0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units									
43.00	INTENSIVE CARE UNIT			15,662,091	6,489	2,413.64	1,404	3,388,751	43.00
44.00	CORONARY CARE UNIT			0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT			0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT			0	0	0.00	0	0	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)							12,302,123	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							25,249,049	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)							1,047,908	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							594,082	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							1,641,990	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							23,607,059	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)							6,566	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,521.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							9,991,876	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0048

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

Worksheet D-1

Date/Time Prepared:
5/27/2021 8:39 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	3,941,021	48,160,808	0.081830	9,991,876	817,635	90.00
91.00 Nursing School cost	0	48,160,808	0.000000	9,991,876	0	91.00
92.00 Allied health cost	0	48,160,808	0.000000	9,991,876	0	92.00
93.00 All other Medical Education	0	48,160,808	0.000000	9,991,876	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/27/2021 8:39 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)		31,648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31,648	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)		25,082	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)		3,634	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)		433	15.00
16.00	Nursery days (title V or XIX only)		75	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		48,160,808	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)		48,160,808	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)		48,160,808	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)		1,521.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,530,076	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,530,076	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0048

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

Worksheet D-1

Date/Time Prepared:
5/27/2021 8:39 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)	1,675,803	433	3,870.21	75	290,266	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	15,662,091	6,489	2,413.64	944	2,278,476	43.00	
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00	
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					1,639,743	48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,738,561	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)						6,566	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,521.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						9,991,876	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048		Period: From 01/01/2020 To 12/31/2020		Worksheet D-1 Date/Time Prepared: 5/27/2021 8:39 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	3,941,021	48,160,808	0.081830	9,991,876	817,635	90.00
91.00	Nursing School cost	0	48,160,808	0.000000	9,991,876	0	91.00
92.00	Allied health cost	0	48,160,808	0.000000	9,991,876	0	92.00
93.00	All other Medical Education	0	48,160,808	0.000000	9,991,876	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/27/2021 8:39 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		14,010,727		30.00
31.00	03100	INTENSIVE CARE UNIT		5,391,275		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.321651	2,013,481	647,638	50.00
51.00	05100	RECOVERY ROOM	0.212158	309,304	65,621	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015940	344,925	5,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102856	7,690,260	790,989	54.00
56.00	05600	RADIOISOTOPE	0.129332	759,834	98,271	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176679	2,241,707	396,063	59.00
60.00	06000	LABORATORY	0.182368	7,780,940	1,418,994	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.200052	3,638,064	727,802	65.00
66.00	06600	PHYSICAL THERAPY	0.382002	1,632,811	623,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.142435	2,065,685	294,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237298	99,122	23,521	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245665	1,117,486	1,392,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.474549	1,252,042	594,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214782	11,742,662	2,522,112	73.00
74.00	07400	RENAL DIALYSIS	0.568669	1,485,995	845,039	74.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.955660	1,867	1,784	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.541371	0	0	90.00
91.00	09100	EMERGENCY	0.166084	5,932,354	985,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537979	1,616,032	869,391	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,724,571	12,302,123	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		51,724,571		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/27/2021 8:39 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,259,556	30.00
31.00	03100	INTENSIVE CARE UNIT		1,487,126	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		378,550	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.321651	268,952	50.00
51.00	05100	RECOVERY ROOM	0.212158	31,056	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015940	74,112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102856	1,200,787	54.00
56.00	05600	RADIOISOTOPE	0.129332	84,818	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176679	288,812	59.00
60.00	06000	LABORATORY	0.182368	1,514,290	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.200052	609,875	65.00
66.00	06600	PHYSICAL THERAPY	0.382002	154,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.142435	303,334	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.237298	9,981	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245665	130,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.474549	44,310	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214782	1,973,230	73.00
74.00	07400	RENAL DIALYSIS	0.568669	150,340	74.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.955660	1,460	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.541371	0	90.00
91.00	09100	EMERGENCY	0.166084	979,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.537979	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,819,785	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)		7,819,785	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/27/2021 8:39 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		12,458,445	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,152,815	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		253,824	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		206.43	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		1.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		-1.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		9.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.84	31.00
32.00	Sum of lines 30 and 31		37.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)		19.91	33.00
34.00	Disproportionate share adjustment (see instructions)		826,825	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/27/2021 8:39 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521
35.01	Factor 3 (see instructions)		0.000199558	0.000193805
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,666,426	2,093,950
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,247,543	527,791
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,775,334	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		19,467,243	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		19,467,243	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,407,229	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		323,829	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		21,198,301	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		21,198,301	61.00
62.00	Deductibles billed to program beneficiaries		1,537,644	62.00
63.00	Coinurance billed to program beneficiaries		40,480	63.00
64.00	Allowable bad debts (see instructions)		691,600	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		449,540	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		452,305	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,069,717	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		39,464	70.93
70.94	HRR adjustment amount (see instructions)		-72,362	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/27/2021 8:39 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,036,819	71.00	
71.01	Sequestration adjustment (see instructions)		132,243	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		19,747,736	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		156,840	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		501,183	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/27/2021 8:39 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,697	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,227,950	2.00
3.00	OPPS payments		4,764,400	3.00
4.00	Outlier payment (see instructions)		103,082	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.790	5.00
6.00	Line 2 times line 5		6,500,081	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		74.88	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)		5,697	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		26,525	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)		26,525	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)		26,525	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		20,828	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)		5,697	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)		4,867,482	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		825,766	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,047,413	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)		4,047,413	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,047,413	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)		373,604	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		242,843	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		262,058	36.00
37.00	Subtotal (see instructions)		4,290,256	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)		4,290,256	40.00
40.01	Sequestration adjustment (see instructions)		28,316	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		4,413,113	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)		-151,173	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
5/27/2021 8:39 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		19,747,736		4,413,113	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)		19,747,736		4,413,113	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		156,840		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		151,173	6.02
7.00	Total Medicare program liability (see instructions)		19,904,576		4,261,940	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: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 5/27/2021 8:39 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 5/27/2021 8:39 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	7,685	8,889		26.00
27.00	Total Inpatient Days (see instructions)	31,753	31,753		27.00
28.00	Ratio of inpatient days to total inpatient days	0.242024	0.279942		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prepared: 5/27/2021 8:39 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,185,371		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		25,249,049		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		25,249,049		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		8,233,647		42.00
43.00	Primary payer payments (see instructions)		0		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		8,233,647		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		33,482,696		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.754092		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.245908		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		0		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		0		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		0		50.00

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

Provider CCN: 14-0048

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

Worksheet G

Date/Time Prepared:
5/27/2021 8:39 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	959,878,000	0	0	0	1.00
2.00 Temporary investments	125,053,000	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	1,587,671,000	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	0	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	706,475,000	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)	3,379,077,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	461,831,000	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	8,014,348,000	0	0	0	15.00
16.00 Accumulated depreciation	0	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	2,520,502,000	0	0	0	23.00
24.00 Accumulated depreciation	0	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	-5,144,704,000	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)	5,851,977,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	11,107,210,000	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	1,111,379,000	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	12,218,589,000	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	21,449,643,000	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,341,619,000	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,207,672,000	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	79,934,000	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	690,637,000	0	0	0	43.00
44.00 Other current liabilities	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	3,319,862,000	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	3,310,401,000	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	2,419,336,000	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	5,729,737,000	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	9,049,599,000	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	12,400,044,000				52.00
53.00 Specific purpose fund	0	0			53.00
54.00 Donor created - endowment fund balance - restricted			0		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	12,400,044,000	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	21,449,643,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0048

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

Worksheet G-1

Date/Time Prepared:
5/27/2021 8:39 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		12,403,312,844		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,268,844				2.00
3.00	Total (sum of line 1 and line 2)		12,400,044,000		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,400,044,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,400,044,000		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0048

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2021 8:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	66,257,663		66,257,663	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	66,257,663		66,257,663	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	24,977,828		24,977,828	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	24,977,828		24,977,828	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	91,235,491		91,235,491	17.00
18.00	Ancillary services	181,501,952	188,832,555	370,334,507	18.00
19.00	Outpatient services	32,276,532	86,452,627	118,729,159	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	NURSERY	2,289,130	0	2,289,130	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	307,303,105	275,285,182	582,588,287	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		181,634,680		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		181,634,680		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0048

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

Worksheet G-3

Date/Time Prepared:
5/27/2021 8:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	582,588,287	1.00
2.00	Less contractual allowances and discounts on patients' accounts	425,956,873	2.00
3.00	Net patient revenues (line 1 minus line 2)	156,631,414	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	181,634,680	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-25,003,266	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY/ MISC INCOME	1,550,074	24.00
24.50	COVID-19 PHE Funding	20,389,807	24.50
25.00	Total other income (sum of lines 6-24)	21,939,881	25.00
26.00	Total (line 5 plus line 25)	-3,063,385	26.00
27.00	NET NON OPERATING INCOME	205,459	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	205,459	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,268,844	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet I-5 Date/Time Prepared: 5/27/2021 8:39 am
			1.00	2.00
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)		0	1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)		0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)		0	2.03
2.04	Outlier payments		0	2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)		0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)		0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients		0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)		0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries		0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012		0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013		0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014		0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014		0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)		0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)		0	6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)		0	8.00
9.00	Program payment (see instructions)		0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)		0	11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)		0	12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)		0	13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)		0.000000	14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0048	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 5/27/2021 8:39 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,280,996	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		25,931	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		86.76	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		9.37	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		27.84	8.00
9.00	Sum of lines 7 and 8		37.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.83	10.00
11.00	Disproportionate share adjustment (see instructions)		100,302	11.00
12.00	Total prospective capital payments (see instructions)		1,407,229	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00