

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/25/2020 9:55 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/25/2020	Time: 9:55 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWESTERN REGIONAL MEDICAL CENTER (14-0100) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) R. LEE PIEKARZ
Officer or Administrator of Provider(s)

REGIONAL CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	2,540	136	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	2,540	136	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: 14-0100		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 9:55 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2501 EMMAUS AVENUE			PO Box:				1.00	
2.00	City: ZION			State: IL		Zip Code: 60099		County: LAKE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	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.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/25/2020 9:55 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/25/2020 9:55 am

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

Worksheet S-2
Part I
Date/Time Prepared:
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MCRIF32 - 16.4.169.4

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 9:55 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		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

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	146,482	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H130	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0100		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 9:55 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: CTCA	Contractor's Name: FCSO		Contractor's Number: 09001				141.00	
142.00	Street: 5900 BROKEN SOUND PARKWAY NW	PO Box:						142.00	
143.00	City: BOCA RATON	State: FL		Zip Code: 33487				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							N	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.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	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)							0.99	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 9:55 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	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.	Y		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.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N	Date	Y/N
		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		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/05/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 9:55 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		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.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TYLER	JOHNSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500	TYLER.JOHNSON@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/25/2020 9:55 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL	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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	49	17,934	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)		49	17,934	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,784	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		73	26,718	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		73			0	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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	868	11	3,054			1.00
2.00	HMO and other (see instructions)	0	0				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)	868	11	3,054			7.00
8.00	INTENSIVE CARE UNIT	729	2	2,912			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,597	13	5,966	0.00	670.72	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	670.72	27.00
28.00	Observation Bed Days		7	784			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	292	9	1,122	1.00
2.00 HMO and other (see instructions)			0	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	292	9	1,122	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/25/2020 9:55 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	44,499,091	0	44,499,091	1,395,106.04	31.90
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,880,683	-15,060	2,865,623	129,141.11	22.19
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		260,910	0	260,910	3,838.75	67.97
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		13,537,070	0	13,537,070	344,359.22	39.31
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,423,570	0	13,423,570		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,369,339	0	1,369,339		
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)		6,562,440	0	6,562,440		
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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/25/2020 9:55 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	688,503	-28,600	659,903	14,103.47	46.79	26.00
27.00	Administrative & General	5.00	5,279,360	20,389	5,299,749	160,946.55	32.93	27.00
28.00	Administrative & General under contract (see inst.)		212,030	0	212,030	1,030.35	205.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,173,408	766	1,174,174	44,173.16	26.58	30.00
31.00	Laundry & Linen Service	8.00	21,092	0	21,092	1,259.25	16.75	31.00
32.00	Housekeeping	9.00	1,285,207	839	1,286,046	83,369.11	15.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,247,552	-1,174,015	73,537	4,270.77	17.22	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,174,830	1,174,830	68,230.36	17.22	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,043,971	682	1,044,653	23,396.21	44.65	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,338,815	1,528	2,340,343	59,678.40	39.22	40.00
41.00	Medical Records & Medical Records Library	16.00	980,925	641	981,566	32,850.82	29.88	41.00
42.00	Social Service	17.00	239,669	157	239,826	7,572.34	31.67	42.00
43.00	Other General Service	18.00	934,262	610	934,872	23,399.34	39.95	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/25/2020 9:55 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	44,711,121	0	44,711,121	1,396,136.39	32.02	1.00
2.00	Excluded area salaries (see instructions)	2,880,683	-15,060	2,865,623	129,141.11	22.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,830,438	15,060	41,845,498	1,266,995.28	33.03	3.00
4.00	Subtotal other wages & related costs (see inst.)	13,797,980	0	13,797,980	348,197.97	39.63	4.00
5.00	Subtotal wage-related costs (see inst.)	19,986,010	0	19,986,010	0.00	47.76	5.00
6.00	Total (sum of lines 3 thru 5)	75,614,428	15,060	75,629,488	1,615,193.25	46.82	6.00
7.00	Total overhead cost (see instructions)	15,444,794	-2,173	15,442,621	524,280.13	29.45	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
11/25/2020 9:55 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,231,866	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,061,612	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	980,726	9.00
10.00	Dental, Hearing and Vision Plan	717,693	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,541	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	344,404	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	654,521	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	12,263	14.00
15.00	'Workers' Compensation Insurance	163,519	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,244,615	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	363,564	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	-416	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,792,908	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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	260,910	14,792,908	1.00
2.00	Hospital	260,910	14,792,908	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0100

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

Worksheet S-10

Date/Time Prepared:
11/25/2020 9:55 am

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.211025	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			617,354	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				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			3,251,075	6.00
7.00	Medicaid cost (line 1 times line 6)			686,058	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)			68,704	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)			68,704	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)	1,209,936	15,691,199	16,901,135	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	255,327	15,691,199	15,946,526	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)	255,327	15,691,199	15,946,526	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)			1,253,310	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			339,650	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			522,538	27.01
28.00	Non-Medicare bad debt expense (see instructions)			730,772	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			337,099	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			16,283,625	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			16,352,329	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0100

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

Worksheet A

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		17,983,406	17,983,406	-63,418	17,919,988	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,759,538	4,759,538	0	4,759,538	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	688,503	9,914,451	10,602,954	191,872	10,794,826	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,279,360	162,939,353	168,218,713	-590,863	167,627,850	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,173,408	3,557,461	4,730,869	766	4,731,635	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,092	574,498	595,590	0	595,590	8.00
9.00	00900	HOUSEKEEPING	1,285,207	522,607	1,807,814	839	1,808,653	9.00
10.00	01000	DIETARY	1,247,552	1,777,477	3,025,029	-2,846,787	178,242	10.00
11.00	01100	CAFETERIA	0	0	0	2,847,602	2,847,602	11.00
13.00	01300	NURSING ADMINISTRATION	1,043,971	233,798	1,277,769	682	1,278,451	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,287,749	1,287,749	0	1,287,749	14.00
15.00	01500	PHARMACY	2,338,815	982,161	3,320,976	1,528	3,322,504	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	980,925	124,205	1,105,130	641	1,105,771	16.00
17.00	01700	SOCIAL SERVICE	239,669	40,484	280,153	157	280,310	17.00
18.00	01850	OTHER GENERAL SERVICES	934,262	216,407	1,150,669	610	1,151,279	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,514,067	763,214	4,277,281	2,295	4,279,576	30.00
31.00	03100	INTENSIVE CARE UNIT	1,038,457	288,521	1,326,978	678	1,327,656	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,774,182	7,313,633	11,087,815	2,465	11,090,280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,101,804	2,327,043	4,428,847	1,373	4,430,220	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,474,900	3,029,755	4,504,655	963	4,505,618	55.00
56.00	05600	RADIOISOTOPE	526,226	4,223,418	4,749,644	344	4,749,988	56.00
57.00	05700	CT SCAN	526,446	504,106	1,030,552	344	1,030,896	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	434,677	493,790	928,467	284	928,751	58.00
60.00	06000	LABORATORY	1,839,906	3,866,292	5,706,198	1,202	5,707,400	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,348,754	1,348,754	0	1,348,754	63.00
64.00	06400	INTRAVENOUS THERAPY	1,311,140	380,434	1,691,574	856	1,692,430	64.00
65.00	06500	RESPIRATORY THERAPY	959,845	427,082	1,386,927	627	1,387,554	65.00
66.00	06600	PHYSICAL THERAPY	1,102,372	175,710	1,278,082	720	1,278,802	66.00
69.00	06900	ELECTROCARDIOLOGY	301,920	102,192	404,112	197	404,309	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,220,223	71,220,223	0	71,220,223	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	409,271	45,304	454,575	267	454,842	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,345,091	900,147	7,245,238	4,144	7,249,382	90.00
91.00	09100	EMERGENCY	725,340	158,907	884,247	474	884,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		162,558	162,558	-337,569	-175,011	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,618,408	302,644,678	344,263,086	-776,707	343,486,379	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	2	2	0	2	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	2,880,683	14,082,235	16,962,918	776,707	17,739,625	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	44,499,091	316,726,915	361,226,006	0	361,226,006	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0100

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

Worksheet A

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,667,747	15,252,241	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,273,048	10,032,586	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-56,953	10,737,873	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-117,327,341	50,300,509	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,731,635	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	595,590	8.00
9.00	00900	HOUSEKEEPING	0	1,808,653	9.00
10.00	01000	DIETARY	0	178,242	10.00
11.00	01100	CAFETERIA	-497,933	2,349,669	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,278,451	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,287,749	14.00
15.00	01500	PHARMACY	-311	3,322,193	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-477	1,105,294	16.00
17.00	01700	SOCIAL SERVICE	0	280,310	17.00
18.00	01850	OTHER GENERAL SERVICES	-12,129	1,139,150	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-20,750	4,258,826	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,327,656	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,090,280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,430,220	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,505,618	55.00
56.00	05600	RADIOISOTOPE	0	4,749,988	56.00
57.00	05700	CT SCAN	0	1,030,896	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	928,751	58.00
60.00	06000	LABORATORY	0	5,707,400	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,348,754	63.00
64.00	06400	INTRAVENOUS THERAPY	-9,688	1,682,742	64.00
65.00	06500	RESPIRATORY THERAPY	-110	1,387,444	65.00
66.00	06600	PHYSICAL THERAPY	-33,763	1,245,039	66.00
69.00	06900	ELECTROCARDIOLOGY	0	404,309	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 PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,220,223	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	-111	454,731	76.01
76.02	03952	PAIN MANAGEMENT	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	7,249,382	90.00
91.00	09100	EMERGENCY	0	884,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	175,011	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-115,179,254	228,307,125	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	2	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	17,739,625	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-115,179,254	246,046,752	200.00

RECLASSIFICATIONS

Provider CCN: 14-0100

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

Worksheet A-6

Date/Time Prepared:
11/25/2020 9:55 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	1,174,830	1,672,772		1.00
	0		1,174,830	1,672,772		
	B - EMPLOYEE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	3,448	0		1.00
2.00	OPERATION OF PLANT	7.00	766	0		2.00
3.00	HOUSEKEEPING	9.00	839	0		3.00
4.00	DIETARY	10.00	815	0		4.00
6.00	NURSING ADMINISTRATION	13.00	682	0		6.00
8.00	PHARMACY	15.00	1,528	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	641	0		9.00
10.00	SOCIAL SERVICE	17.00	157	0		10.00
11.00	OTHER GENERAL SERVICES	18.00	610	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	2,295	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	678	0		13.00
15.00	OPERATING ROOM	50.00	2,465	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	1,373	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	963	0		17.00
18.00	RADIOISOTOPE	56.00	344	0		18.00
19.00	CT SCAN	57.00	344	0		19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	284	0		20.00
21.00	LABORATORY	60.00	1,202	0		21.00
23.00	INTRAVENOUS THERAPY	64.00	856	0		23.00
24.00	RESPIRATORY THERAPY	65.00	627	0		24.00
25.00	PHYSICAL THERAPY	66.00	720	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	197	0		26.00
27.00	HOSPITAL NUTRITION	76.01	267	0		27.00
29.00	CLINIC	90.00	4,144	0		29.00
30.00	EMERGENCY	91.00	474	0		30.00
33.00	OTHER NONREIMBURSABLE EXPENSES	194.00	1,881	0		33.00
	0		28,600	0		
	C - PROPERTY TAX					
1.00	OTHER NONREIMBURSABLE EXPENSES	194.00	0	800,487		1.00
	0		0	800,487		
	D - TRAVEL/SCHEDULING					
1.00	OTHER NONREIMBURSABLE EXPENSES	194.00	13,899	1,684		1.00
	0		13,899	1,684		
	E - GUEST SERVICES					
1.00		0.00	0	0		1.00
	0		0	0		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	337,569		1.00
	0		0	337,569		
	G - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	407,174		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	220,472		2.00
	0		0	627,646		
	H - TRANSPORTATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	30,840	18,078		1.00
	0		30,840	18,078		
	I - GUEST ACCOMODATIONS DEPRECIATION					
1.00	OTHER NONREIMBURSABLE EXPENSES	194.00	0	7,674		1.00
	0		0	7,674		
500.00	Grand Total: Increases		1,248,169	3,465,910		500.00

RECLASSIFICATIONS

Provider CCN: 14-0100

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

Worksheet A-6

Date/Time Prepared:
11/25/2020 9:55 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	1,174,830	1,672,772	0		1.00
	0		1,174,830	1,672,772			
	B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28,600	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
6.00		0.00	0	0	0		6.00
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
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
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
33.00		0.00	0	0	0		33.00
	0		28,600	0			
	C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	800,487	13		1.00
	0		0	800,487			
	D - TRAVEL/SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	13,899	1,684	0		1.00
	0		13,899	1,684			
	E - GUEST SERVICES						
1.00		0.00	0	0	0		1.00
	0		0	0			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	337,569	11		1.00
	0		0	337,569			
	G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	627,646	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	627,646			
	H - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE EXPENSES	194.00	30,840	18,078	0		1.00
	0		30,840	18,078			
	I - GUEST ACCOMODATIONS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,674	9		1.00
	0		0	7,674			
500.00	Grand Total: Decreases		1,248,169	3,465,910			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/25/2020 9:55 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	1,126,605	0	0	0	0	2.00	
3.00	Buildings and Fixtures	34,113,556	0	0	0	11,978,490	3.00	
4.00	Building Improvements	171,309,591	11,932,259	0	11,932,259	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	95,697,171	452,505	0	452,505	78,913	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	302,246,923	12,384,764	0	12,384,764	12,057,403	8.00	
9.00	Reconciling Items	12,074,483	-11,978,490	0	-11,978,490	0	9.00	
10.00	Total (line 8 minus line 9)	290,172,440	24,363,254	0	24,363,254	12,057,403	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	0	0					1.00
2.00	Land Improvements	1,126,605	0					
3.00	Buildings and Fixtures	22,135,066	0					
4.00	Building Improvements	183,241,850	0					4.00
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	96,070,763	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	302,574,284	0					
9.00	Reconciling Items	95,993	0					
10.00	Total (line 8 minus line 9)	302,478,291	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	10,824,912	0	0	0	4,429,782	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,334,295	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,159,207	0	0	0	4,429,782	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,728,712	17,983,406				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,425,243	4,759,538				2.00
3.00	Total (sum of lines 1-2)	5,153,955	22,742,944				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	206,503,521	30,640,020	175,863,501	0.789342	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	96,070,762	49,136,794	46,933,968	0.210658	0	2.00
3.00	Total (sum of lines 1-2)	302,574,283	79,776,814	222,797,469	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,821,759	-3,601,185	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,607,343	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,429,102	-3,601,185	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	337,569	336,091	3,629,295	2,728,712	15,252,241	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,425,243	10,032,586	2.00
3.00	Total (sum of lines 1-2)	337,569	336,091	3,629,295	5,153,955	25,284,827	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0100

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

Worksheet A-8

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00			2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	A-8-2	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	-100,866,318			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-497,933	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
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 - CAP REL COSTS-BLDG & FIXT	A	-34,292	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	2,121,730	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0100

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

Worksheet A-8

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE	B	-32,803	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE	B	-477	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	OTHER REVENUE	B	-716	OTHER GENERAL SERVICES	18.00	0	33.02
33.03	OTHER REVENUE	B	-9,688	INTRAVENOUS THERAPY	64.00	0	33.03
33.04	OTHER REVENUE	B	-33,763	PHYSICAL THERAPY	66.00	0	33.04
33.05	OTHER REVENUE	B	-20,750	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	OTHER REVENUE	B	-111	HOSPITAL NUTRITION	76.01	0	33.06
33.07	NON-ALLOWABLE EXPENSE	A	-11,413	OTHER GENERAL SERVICES	18.00	0	33.07
33.08	NON-ALLOWABLE EXPENSE	A	-15,723,510	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	NON-ALLOWABLE EXPENSE	A	-110	RESPIRATORY THERAPY	65.00	0	33.09
33.10	NON-ALLOWABLE EXPENSE	A	-311	PHARMACY	15.00	0	33.10
33.11	LOBBYING EXPENSE	A	-68,789	ADMINISTRATIVE & GENERAL	5.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-115,179,254				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: 14-0100

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

Worksheet A-8-1

Date/Time Prepared:
11/25/2020 9:55 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	81,124	0	1.00
2.00	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	558,697	558,697	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	437,755	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	66,933	4.01
4.02	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	337,569	0	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	-909,484	2,691,701	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	43,995,469	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	97,458,112	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE	336,091	407,174	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE	163,519	220,472	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	669,828	871,793	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,038,813	0	4.09
4.10	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,589,073	0	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	40,072,183	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
5.00	0		0	45,937,413	146,803,731	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	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
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: 14-0100

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

Worksheet A-8-1

Date/Time Prepared:
11/25/2020 9:55 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	81,124	0		1.00
2.00	-95,625	0		2.00
3.00	0	9		3.00
4.00	-437,755	9		4.00
4.01	-66,933	0		4.01
4.02	337,569	0		4.02
4.03	-3,601,185	10		4.03
4.04	-43,995,469	0		4.04
4.05	-97,458,112	0		4.05
4.06	-71,083	12		4.06
4.07	-56,953	0		4.07
4.08	-201,965	0		4.08
4.09	1,038,813	9		4.09
4.10	3,589,073	9		4.10
4.11	40,072,183	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	-100,866,318			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	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
10.07			10.07
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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	15,252,241	15,252,241			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,032,586		10,032,586		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,737,873	84,198	2,433	10,824,504	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,300,509	730,240	3,611,882	1,308,582	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,731,635	2,232,385	376,392	289,920	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	595,590	0	0	5,208	8.00
9.00	00900	HOUSEKEEPING	1,808,653	209,277	27,024	317,543	9.00
10.00	01000	DIETARY	178,242	42,822	172,078	18,157	10.00
11.00	01100	CAFETERIA	2,349,669	684,115	0	290,082	11.00
13.00	01300	NURSING ADMINISTRATION	1,278,451	39,725	0	257,939	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,287,749	154,026	351,396	0	14.00
15.00	01500	PHARMACY	3,322,193	145,189	375,879	577,863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,105,294	161,913	0	242,362	16.00
17.00	01700	SOCIAL SERVICE	280,310	45,299	0	59,216	17.00
18.00	01850	OTHER GENERAL SERVICES	1,139,150	76,600	596	230,833	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,258,826	2,051,435	488,880	868,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,327,656	749,152	153,947	256,577	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,090,280	1,077,356	1,328,809	932,507	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,430,220	456,586	488,241	519,304	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,505,618	533,970	1,732,104	364,411	55.00
56.00	05600	RADIOISOTOPE	4,749,988	16,518	7,233	130,018	56.00
57.00	05700	CT SCAN	1,030,896	43,854	0	130,072	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928,751	61,363	25,713	107,398	58.00
60.00	06000	LABORATORY	5,707,400	360,536	309,759	454,595	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,348,754	12,058	129,756	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,682,742	394,273	104,181	323,950	64.00
65.00	06500	RESPIRATORY THERAPY	1,387,444	7,433	16,779	237,154	65.00
66.00	06600	PHYSICAL THERAPY	1,245,039	216,297	6,131	272,369	66.00
69.00	06900	ELECTROCARDIOLOGY	404,309	22,092	34,445	74,597	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,220,223	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	454,731	30,434	0	101,121	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,249,382	1,712,661	85,409	1,567,710	90.00
91.00	09100	EMERGENCY	884,721	94,976	51,218	179,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	228,307,125	12,446,783	9,880,285	10,116,941	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,524	0	0	190.00
191.00	19100	RESEARCH	2	103,235	953	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	17,739,625	2,658,699	151,348	707,563	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	246,046,752	15,252,241	10,032,586	10,824,504	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	55,951,213					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,245,851	0	9,876,183			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	176,834	0	0	777,632		8.00
9.00	00900	HOUSEKEEPING	695,358	0	169,248	15,103	3,242,206	9.00
10.00	01000	DIETARY	121,058	0	34,631	0	11,573	10.00
11.00	01100	CAFETERIA	978,320	0	553,261	0	184,896	11.00
13.00	01300	NURSING ADMINISTRATION	463,901	0	32,126	0	10,736	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	527,788	0	124,565	0	41,629	14.00
15.00	01500	PHARMACY	1,301,278	0	117,418	0	39,240	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	444,314	0	130,943	0	43,760	16.00
17.00	01700	SOCIAL SERVICE	113,266	0	36,635	0	12,243	17.00
18.00	01850	OTHER GENERAL SERVICES	425,951	0	61,948	1,069	20,703	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,256,755	0	1,659,049	138,291	554,443	30.00
31.00	03100	INTENSIVE CARE UNIT	732,101	0	605,859	2,212	202,474	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,246,902	0	871,285	88,757	291,178	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,734,896	0	369,253	253,798	123,402	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,100,383	0	431,836	0	144,317	55.00
56.00	05600	RADIOISOTOPE	1,443,333	0	13,358	0	4,464	56.00
57.00	05700	CT SCAN	354,618	0	35,466	0	11,852	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	330,601	0	49,626	0	16,585	58.00
60.00	06000	LABORATORY	2,010,962	0	291,575	0	97,442	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	438,722	0	9,751	0	3,259	63.00
64.00	06400	INTRAVENOUS THERAPY	737,345	0	318,859	46,601	106,561	64.00
65.00	06500	RESPIRATORY THERAPY	485,298	0	6,011	0	2,009	65.00
66.00	06600	PHYSICAL THERAPY	512,089	0	174,925	12,181	58,459	66.00
69.00	06900	ELECTROCARDIOLOGY	157,598	0	17,867	11,429	5,971	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,962,405	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	172,563	0	24,612	0	8,225	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,124,382	0	1,385,073	50,697	462,882	90.00
91.00	09100	EMERGENCY	356,180	0	76,809	14,649	25,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,651,052	0	7,601,989	634,787	2,483,972	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,811	0	35,199	0	11,763	190.00
191.00	19100	RESEARCH	30,666	0	83,488	0	27,901	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	6,256,684	0	2,155,507	142,845	718,570	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)	55,951,213	0	9,876,183	777,632	3,242,206	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	578,561					10.00
11.00	01100	CAFETERIA	0	5,040,343				11.00
13.00	01300	NURSING ADMINISTRATION	0	115,753	2,198,631			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,487,153		14.00
15.00	01500	PHARMACY	0	295,261	0	0	6,174,321	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	162,532	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	37,463	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	0	115,768	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	323,256	443,549	900,827	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	159,341	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	519,351	717,643	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,004	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	214,289	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	59,346	0	0	0	56.00
57.00	05700	CT SCAN	0	72,032	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	55,907	0	0	0	58.00
60.00	06000	LABORATORY	0	308,590	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	255,305	167,619	377,268	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	129,127	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	153,958	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	32,540	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	2,487,153	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,174,321	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	61,894	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	954,940	0	0	0	90.00
91.00	09100	EMERGENCY	0	90,145	202,893	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	578,561	4,401,409	2,198,631	2,487,153	6,174,321	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	638,934	0	0	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)	578,561	5,040,343	2,198,631	2,487,153	6,174,321	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,291,118					16.00
17.00	01700	SOCIAL SERVICE	0	584,432				17.00
18.00	01850	OTHER GENERAL SERVICES	0	0	2,072,618			18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,175	9,994	35,438	14,028,157	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,388	3,415	12,111	4,218,233	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	198,934	50,749	179,959	21,593,710	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,254	21,238	75,313	8,807,509	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	138,821	35,413	125,579	10,326,741	0	55.00
56.00	05600	RADIOISOTOPE	49,905	12,731	45,145	6,532,039	0	56.00
57.00	05700	CT SCAN	154,689	39,462	139,934	2,012,875	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,272	10,529	37,335	1,665,080	0	58.00
60.00	06000	LABORATORY	135,883	34,664	122,921	9,834,327	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,606	4,236	15,022	1,978,164	0	63.00
64.00	06400	INTRAVENOUS THERAPY	50,618	12,913	45,790	4,624,025	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,095	3,341	11,846	2,299,537	0	65.00
66.00	06600	PHYSICAL THERAPY	7,186	1,833	6,501	2,666,968	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,590	2,701	9,580	783,719	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,314	2,631	9,330	2,509,428	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,294,209	330,117	1,170,800	101,152,075	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,943	496	1,757	857,776	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,126	6,665	23,634	16,649,561	0	90.00
91.00	09100	EMERGENCY	5,110	1,304	4,623	1,987,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,291,118	584,432	2,072,618	214,527,435	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	103,297	0	190.00
191.00	19100	RESEARCH	0	0	0	246,245	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	0	0	31,169,775	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,291,118	584,432	2,072,618	246,046,752	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
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
18.00	01850	OTHER GENERAL SERVICES	18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
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 PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	76.00
76.01	03951	HOSPITAL NUTRITION	76.01
76.02	03952	PAIN MANAGEMENT	76.02
76.03	03954	INFUSION CENTER	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	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: 14-0100

Period:
From 07/01/2019
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	84,198	2,433	86,631	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	730,240	3,611,882	4,342,122	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,232,385	376,392	2,608,777	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	42	8.00
9.00	00900	HOUSEKEEPING	0	209,277	27,024	236,301	9.00
10.00	01000	DIETARY	0	42,822	172,078	214,900	10.00
11.00	01100	CAFETERIA	0	684,115	0	684,115	11.00
13.00	01300	NURSING ADMINISTRATION	0	39,725	0	39,725	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	154,026	351,396	505,422	14.00
15.00	01500	PHARMACY	0	145,189	375,879	521,068	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	161,913	0	161,913	16.00
17.00	01700	SOCIAL SERVICE	0	45,299	0	45,299	17.00
18.00	01850	OTHER GENERAL SERVICES	0	76,600	596	77,196	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,051,435	488,880	2,540,315	30.00
31.00	03100	INTENSIVE CARE UNIT	0	749,152	153,947	903,099	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,077,356	1,328,809	2,406,165	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	456,586	488,241	944,827	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	533,970	1,732,104	2,266,074	55.00
56.00	05600	RADIOISOTOPE	0	16,518	7,233	23,751	56.00
57.00	05700	CT SCAN	0	43,854	0	43,854	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	61,363	25,713	87,076	58.00
60.00	06000	LABORATORY	0	360,536	309,759	670,295	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	12,058	129,756	141,814	63.00
64.00	06400	INTRAVENOUS THERAPY	0	394,273	104,181	498,454	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,433	16,779	24,212	65.00
66.00	06600	PHYSICAL THERAPY	0	216,297	6,131	222,428	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,092	34,445	56,537	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	30,434	0	30,434	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,712,661	85,409	1,798,070	90.00
91.00	09100	EMERGENCY	0	94,976	51,218	146,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,446,783	9,880,285	22,327,068	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,524	0	43,524	190.00
191.00	19100	RESEARCH	0	103,235	953	104,188	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	2,658,699	151,348	2,810,047	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	15,252,241	10,032,586	25,284,827	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,352,594					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	174,712	0	2,785,809			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,756	0	0	13,798		8.00
9.00	00900	HOUSEKEEPING	54,094	0	47,740	268	340,944	9.00
10.00	01000	DIETARY	9,418	0	9,768	0	1,217	10.00
11.00	01100	CAFETERIA	76,107	0	156,060	0	19,443	11.00
13.00	01300	NURSING ADMINISTRATION	36,088	0	9,062	0	1,129	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,058	0	35,136	0	4,378	14.00
15.00	01500	PHARMACY	101,230	0	33,121	0	4,126	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,565	0	36,936	0	4,602	16.00
17.00	01700	SOCIAL SERVICE	8,811	0	10,334	0	1,287	17.00
18.00	01850	OTHER GENERAL SERVICES	33,136	0	17,474	19	2,177	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	175,560	0	467,974	2,454	58,304	30.00
31.00	03100	INTENSIVE CARE UNIT	56,952	0	170,897	39	21,292	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	330,380	0	245,766	1,575	30,620	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,963	0	104,156	4,502	12,977	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	163,395	0	121,809	0	15,176	55.00
56.00	05600	RADIOISOTOPE	112,281	0	3,768	0	469	56.00
57.00	05700	CT SCAN	27,587	0	10,004	0	1,246	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,718	0	13,998	0	1,744	58.00
60.00	06000	LABORATORY	156,439	0	82,246	0	10,247	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	34,130	0	2,751	0	343	63.00
64.00	06400	INTRAVENOUS THERAPY	57,360	0	89,942	827	11,206	64.00
65.00	06500	RESPIRATORY THERAPY	37,753	0	1,696	0	211	65.00
66.00	06600	PHYSICAL THERAPY	39,837	0	49,342	216	6,147	66.00
69.00	06900	ELECTROCARDIOLOGY	12,260	0	5,040	203	628	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,630,707	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	13,424	0	6,943	0	865	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	243,055	0	390,692	900	48,676	90.00
91.00	09100	EMERGENCY	27,708	0	21,666	260	2,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,862,484	0	2,144,321	11,263	261,209	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	997	0	9,929	0	1,237	190.00
191.00	19100	RESEARCH	2,386	0	23,550	0	2,934	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	486,727	0	608,009	2,535	75,564	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)	4,352,594	0	2,785,809	13,798	340,944	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	235,448					10.00
11.00	01100	CAFETERIA	0	938,046				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,543	109,611			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	585,994		14.00
15.00	01500	PHARMACY	0	54,950	0	0	719,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,249	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,972	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	0	21,545	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	131,550	82,548	44,910	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,655	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	96,655	35,778	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,900	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	39,881	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	11,045	0	0	0	56.00
57.00	05700	CT SCAN	0	13,406	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,405	0	0	0	58.00
60.00	06000	LABORATORY	0	57,431	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	103,898	31,195	18,808	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	24,031	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,653	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,056	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	585,994	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	719,120	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	11,519	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	177,720	0	0	0	90.00
91.00	09100	EMERGENCY	0	16,777	10,115	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,448	819,136	109,611	585,994	719,120	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	118,910	0	0	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)	235,448	938,046	109,611	585,994	719,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	270,205					16.00
17.00	01700	SOCIAL SERVICE	0	73,177				17.00
18.00	01850	OTHER GENERAL SERVICES	0	0	153,394			18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,623	1,251	2,624	3,519,061	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,580	428	897	1,186,892	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,477	6,355	13,327	3,197,561	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,825	2,659	5,577	1,270,542	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	16,383	4,434	9,300	2,639,368	0	55.00
56.00	05600	RADIOISOTOPE	5,889	1,594	3,343	163,181	0	56.00
57.00	05700	CT SCAN	18,255	4,941	10,363	130,697	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,871	1,318	2,765	148,754	0	58.00
60.00	06000	LABORATORY	16,036	4,341	9,103	1,009,776	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,960	530	1,112	182,640	0	63.00
64.00	06400	INTRAVENOUS THERAPY	5,974	1,617	3,391	825,265	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,545	418	877	92,641	0	65.00
66.00	06600	PHYSICAL THERAPY	848	230	481	350,362	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,250	338	709	83,618	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,217	329	691	588,231	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,557	41,334	86,612	2,630,330	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	229	62	130	64,415	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,083	835	1,750	2,677,333	0	90.00
91.00	09100	EMERGENCY	603	163	342	227,961	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	270,205	73,177	153,394	20,988,628	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	55,687	0	190.00
191.00	19100	RESEARCH	0	0	0	133,058	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	0	0	4,107,454	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	270,205	73,177	153,394	25,284,827	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
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
18.00	01850	OTHER GENERAL SERVICES	18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
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 PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	76.00
76.01	03951	HOSPITAL NUTRITION	76.01
76.02	03952	PAIN MANAGEMENT	76.02
76.03	03954	INFUSION CENTER	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	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: 14-0100

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	369,359					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,032,585				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,039	2,433	43,839,188			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,684	3,611,881	5,299,749	-55,951,213	190,095,539	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,061	376,392	1,174,174	0	7,630,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	21,092	0	600,798	8.00
9.00	00900	HOUSEKEEPING	5,068	27,024	1,286,046	0	2,362,497	9.00
10.00	01000	DIETARY	1,037	172,078	73,537	0	411,299	10.00
11.00	01100	CAFETERIA	16,567	0	1,174,830	0	3,323,866	11.00
13.00	01300	NURSING ADMINISTRATION	962	0	1,044,653	0	1,576,115	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	351,396	0	0	1,793,171	14.00
15.00	01500	PHARMACY	3,516	375,879	2,340,342	0	4,421,124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	981,566	0	1,509,569	16.00
17.00	01700	SOCIAL SERVICE	1,097	0	239,826	0	384,825	17.00
18.00	01850	OTHER GENERAL SERVICES	1,855	596	934,872	0	1,447,179	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,679	488,880	3,516,362	0	7,667,380	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	153,947	1,039,135	0	2,487,332	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,090	1,328,809	3,776,647	0	14,428,952	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	488,241	2,103,177	0	5,894,351	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	1,732,104	1,475,863	0	7,136,103	55.00
56.00	05600	RADIOISOTOPE	400	7,233	526,570	0	4,903,757	56.00
57.00	05700	CT SCAN	1,062	0	526,790	0	1,204,822	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	25,713	434,961	0	1,123,225	58.00
60.00	06000	LABORATORY	8,731	309,759	1,841,108	0	6,832,290	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	129,756	0	0	1,490,568	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	104,181	1,311,996	0	2,505,146	64.00
65.00	06500	RESPIRATORY THERAPY	180	16,779	960,472	0	1,648,810	65.00
66.00	06600	PHYSICAL THERAPY	5,238	6,131	1,103,092	0	1,739,836	66.00
69.00	06900	ELECTROCARDIOLOGY	535	34,445	302,117	0	535,443	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	71,220,223	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	0	409,538	0	586,286	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,475	85,409	6,349,235	0	10,615,162	90.00
91.00	09100	EMERGENCY	2,300	51,218	725,814	0	1,210,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	301,420	9,880,284	40,973,564	-55,951,213	168,690,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	0	0	43,524	190.00
191.00	19100	RESEARCH	2,500	953	0	0	104,190	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	64,385	151,348	2,865,624	0	21,257,235	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	15,252,241	10,032,586	10,824,504		55,951,213	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.293812	1.000000	0.246914		0.294332	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			86,631		4,352,594	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001976		0.022897	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: 14-0100

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	349,636					6.00
7.00	00700	OPERATION OF PLANT	54,061	295,735				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	308,357			8.00
9.00	00900	HOUSEKEEPING	5,068	5,068	5,989	290,507		9.00
10.00	01000	DIETARY	1,037	1,037	0	1,037	27,042	10.00
11.00	01100	CAFETERIA	16,567	16,567	0	16,567	0	11.00
13.00	01300	NURSING ADMINISTRATION	962	962	0	962	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	3,730	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	1,097	1,097	0	1,097	0	17.00
18.00	01850	OTHER GENERAL SERVICES	1,855	1,855	424	1,855	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,679	49,679	54,837	49,679	15,109	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	18,142	877	18,142	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,090	26,090	35,195	26,090	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	11,057	100,639	11,057	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	0	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	1,062	1,062	0	1,062	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	8,731	8,731	0	8,731	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	9,548	18,479	9,548	11,933	64.00
65.00	06500	RESPIRATORY THERAPY	180	180	0	180	0	65.00
66.00	06600	PHYSICAL THERAPY	5,238	5,238	4,830	5,238	0	66.00
69.00	06900	ELECTROCARDIOLOGY	535	535	4,532	535	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,475	41,475	20,103	41,475	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	5,809	2,300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	281,697	227,636	251,714	222,568	27,042	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	1,054	0	1,054	0	190.00
191.00	19100	RESEARCH	2,500	2,500	0	2,500	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	64,385	64,545	56,643	64,385	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	9,876,183	777,632	3,242,206	578,561	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	33.395381	2.521856	11.160509	21.394904	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,785,809	13,798	340,944	235,448	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.419950	0.044747	1.173617	8.706752	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: 14-0100

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,018,752					11.00
13.00	01300	NURSING ADMINISTRATION	23,396	197,439				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,000			14.00
15.00	01500	PHARMACY	59,678	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,851	0	0	0	1,016,595,814	16.00
17.00	01700	SOCIAL SERVICE	7,572	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	23,399	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	89,650	80,895	0	0	17,380,084	30.00
31.00	03100	INTENSIVE CARE UNIT	32,206	0	0	0	5,939,444	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,971	64,445	0	0	88,258,288	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,935	0	0	0	36,936,303	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	43,312	0	0	0	61,588,652	55.00
56.00	05600	RADIOISOTOPE	11,995	0	0	0	22,140,664	56.00
57.00	05700	CT SCAN	14,559	0	0	0	68,628,836	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,300	0	0	0	18,310,594	58.00
60.00	06000	LABORATORY	62,372	0	0	0	60,285,054	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	7,367,278	63.00
64.00	06400	INTRAVENOUS THERAPY	33,879	33,879	0	0	22,456,993	64.00
65.00	06500	RESPIRATORY THERAPY	26,099	0	0	0	5,809,592	65.00
66.00	06600	PHYSICAL THERAPY	31,118	0	0	0	3,188,110	66.00
69.00	06900	ELECTROCARDIOLOGY	6,577	0	0	0	4,698,230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	0	4,575,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	574,311,846	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	12,510	0	0	0	861,908	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	193,012	0	0	0	11,591,030	90.00
91.00	09100	EMERGENCY	18,220	18,220	0	0	2,267,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	889,611	197,439	1,000	1,000	1,016,595,814	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	129,141	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,040,343	2,198,631	2,487,153	6,174,321	2,291,118	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.947566	11.135748	2,487.153000	6,174.321000	0.002254	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	938,046	109,611	585,994	719,120	270,205	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.920780	0.555164	585.994000	719.120000	0.000266	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: 14-0100

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE S (GROSS CHARGES)	
			17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	1,016,595,814		17.00
18.00	01850	OTHER GENERAL SERVICES	0	1,016,595,814	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	17,380,084	17,380,084	30.00
31.00	03100	INTENSIVE CARE UNIT	5,939,444	5,939,444	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	88,258,288	88,258,288	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,936,303	36,936,303	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	61,588,652	61,588,652	55.00
56.00	05600	RADIOISOTOPE	22,140,664	22,140,664	56.00
57.00	05700	CT SCAN	68,628,836	68,628,836	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,310,594	18,310,594	58.00
60.00	06000	LABORATORY	60,285,054	60,285,054	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,367,278	7,367,278	63.00
64.00	06400	INTRAVENOUS THERAPY	22,456,993	22,456,993	64.00
65.00	06500	RESPIRATORY THERAPY	5,809,592	5,809,592	65.00
66.00	06600	PHYSICAL THERAPY	3,188,110	3,188,110	66.00
69.00	06900	ELECTROCARDIOLOGY	4,698,230	4,698,230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,575,861	4,575,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	574,311,846	574,311,846	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	861,908	861,908	76.01
76.02	03952	PAIN MANAGEMENT	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	11,591,030	11,591,030	90.00
91.00	09100	EMERGENCY	2,267,047	2,267,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,016,595,814	1,016,595,814	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	584,432	2,072,618	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000575	0.002039	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,177	153,394	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000072	0.000151	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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:55 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	14,028,157		14,028,157	0	14,028,157	30.00	
31.00	03100	INTENSIVE CARE UNIT	4,218,233		4,218,233	0	4,218,233	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	21,593,710		21,593,710	0	21,593,710	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,807,509		8,807,509	0	8,807,509	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	10,326,741		10,326,741	0	10,326,741	55.00	
56.00	05600	RADIOISOTOPE	6,532,039		6,532,039	0	6,532,039	56.00	
57.00	05700	CT SCAN	2,012,875		2,012,875	0	2,012,875	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,665,080		1,665,080	0	1,665,080	58.00	
60.00	06000	LABORATORY	9,834,327		9,834,327	0	9,834,327	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,978,164		1,978,164	0	1,978,164	63.00	
64.00	06400	INTRAVENOUS THERAPY	4,624,025		4,624,025	0	4,624,025	64.00	
65.00	06500	RESPIRATORY THERAPY	2,299,537	0	2,299,537	0	2,299,537	65.00	
66.00	06600	PHYSICAL THERAPY	2,666,968	0	2,666,968	0	2,666,968	66.00	
69.00	06900	ELECTROCARDIOLOGY	783,719		783,719	0	783,719	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,509,428		2,509,428	0	2,509,428	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	101,152,075		101,152,075	0	101,152,075	73.00	
76.00	03950	OTHER ANCILLARY EXPENSE	0		0	0	0	76.00	
76.01	03951	HOSPITAL NUTRITION	857,776		857,776	0	857,776	76.01	
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02	
76.03	03954	INFUSION CENTER	0		0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	16,649,561		16,649,561	0	16,649,561	90.00	
91.00	09100	EMERGENCY	1,987,511		1,987,511	0	1,987,511	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,865,575		2,865,575	0	2,865,575	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	217,393,010	0	217,393,010	0	217,393,010	200.00	
201.00		Less Observation Beds	2,865,575		2,865,575		2,865,575	201.00	
202.00		Total (see instructions)	214,527,435	0	214,527,435	0	214,527,435	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/25/2020 9:55 am	
					Title XVIII		Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,316,336		15,316,336			30.00
31.00	03100	INTENSIVE CARE UNIT	5,939,444		5,939,444			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,765,174	55,493,114	88,258,288	0.244665	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,302,845	32,633,458	36,936,303	0.238451	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,453,066	60,135,586	61,588,652	0.167673	0.000000	55.00
56.00	05600	RADIOISOTOPE	206,108	21,934,556	22,140,664	0.295025	0.000000	56.00
57.00	05700	CT SCAN	2,936,615	65,692,221	68,628,836	0.029330	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	956,792	17,353,802	18,310,594	0.090935	0.000000	58.00
60.00	06000	LABORATORY	10,413,456	49,871,598	60,285,054	0.163130	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,032,056	2,335,222	7,367,278	0.268507	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	90,579	22,366,414	22,456,993	0.205906	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,212,092	3,597,500	5,809,592	0.395817	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,324,531	1,863,579	3,188,110	0.836536	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	664,454	4,033,776	4,698,230	0.166812	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,776,774	1,799,087	4,575,861	0.548406	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,358,931	523,952,915	574,311,846	0.176127	0.000000	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	135,958	725,950	861,908	0.995206	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	153,257	11,437,773	11,591,030	1.436418	0.000000	90.00
91.00	09100	EMERGENCY	938,992	1,328,055	2,267,047	0.876696	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	599,838	1,463,910	2,063,748	1.388530	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	138,577,298	878,018,516	1,016,595,814			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	138,577,298	878,018,516	1,016,595,814			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:55 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
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.244665			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238451			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.167673			55.00
56.00	05600	RADIOISOTOPE	0.295025			56.00
57.00	05700	CT SCAN	0.029330			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090935			58.00
60.00	06000	LABORATORY	0.163130			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.268507			63.00
64.00	06400	INTRAVENOUS THERAPY	0.205906			64.00
65.00	06500	RESPIRATORY THERAPY	0.395817			65.00
66.00	06600	PHYSICAL THERAPY	0.836536			66.00
69.00	06900	ELECTROCARDIOLOGY	0.166812			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548406			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176127			73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000			76.00
76.01	03951	HOSPITAL NUTRITION	0.995206			76.01
76.02	03952	PAIN MANAGEMENT	0.000000			76.02
76.03	03954	INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.436418			90.00
91.00	09100	EMERGENCY	0.876696			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.388530			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:55 am

			Title XIX		Hospital		Cost	
	Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,028,157		14,028,157	0	14,028,157	30.00
31.00	03100	INTENSIVE CARE UNIT	4,218,233		4,218,233	0	4,218,233	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,593,710		21,593,710	0	21,593,710	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,807,509		8,807,509	0	8,807,509	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,326,741		10,326,741	0	10,326,741	55.00
56.00	05600	RADIOISOTOPE	6,532,039		6,532,039	0	6,532,039	56.00
57.00	05700	CT SCAN	2,012,875		2,012,875	0	2,012,875	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,665,080		1,665,080	0	1,665,080	58.00
60.00	06000	LABORATORY	9,834,327		9,834,327	0	9,834,327	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,978,164		1,978,164	0	1,978,164	63.00
64.00	06400	INTRAVENOUS THERAPY	4,624,025		4,624,025	0	4,624,025	64.00
65.00	06500	RESPIRATORY THERAPY	2,299,537	0	2,299,537	0	2,299,537	65.00
66.00	06600	PHYSICAL THERAPY	2,666,968	0	2,666,968	0	2,666,968	66.00
69.00	06900	ELECTROCARDIOLOGY	783,719		783,719	0	783,719	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,509,428		2,509,428	0	2,509,428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,152,075		101,152,075	0	101,152,075	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	857,776		857,776	0	857,776	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	16,649,561		16,649,561	0	16,649,561	90.00
91.00	09100	EMERGENCY	1,987,511		1,987,511	0	1,987,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,865,575		2,865,575	0	2,865,575	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	217,393,010	0	217,393,010	0	217,393,010	200.00
201.00		Less Observation Beds	2,865,575		2,865,575		2,865,575	201.00
202.00		Total (see instructions)	214,527,435	0	214,527,435	0	214,527,435	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:55 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	15,316,336		15,316,336			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,939,444		5,939,444			31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,765,174	55,493,114	88,258,288	0.244665	0.000000	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,302,845	32,633,458	36,936,303	0.238451	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,453,066	60,135,586	61,588,652	0.167673	0.000000	55.00	
56.00	05600	RADIOISOTOPE	206,108	21,934,556	22,140,664	0.295025	0.000000	56.00	
57.00	05700	CT SCAN	2,936,615	65,692,221	68,628,836	0.029330	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	956,792	17,353,802	18,310,594	0.090935	0.000000	58.00	
60.00	06000	LABORATORY	10,413,456	49,871,598	60,285,054	0.163130	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,032,056	2,335,222	7,367,278	0.268507	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	90,579	22,366,414	22,456,993	0.205906	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	2,212,092	3,597,500	5,809,592	0.395817	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,324,531	1,863,579	3,188,110	0.836536	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	664,454	4,033,776	4,698,230	0.166812	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,776,774	1,799,087	4,575,861	0.548406	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	50,358,931	523,952,915	574,311,846	0.176127	0.000000	73.00	
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0.000000	0.000000	76.00	
76.01	03951	HOSPITAL NUTRITION	135,958	725,950	861,908	0.995206	0.000000	76.01	
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02	
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	153,257	11,437,773	11,591,030	1.436418	0.000000	90.00	
91.00	09100	EMERGENCY	938,992	1,328,055	2,267,047	0.876696	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	599,838	1,463,910	2,063,748	1.388530	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	138,577,298	878,018,516	1,016,595,814			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	138,577,298	878,018,516	1,016,595,814			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
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
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
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 PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000			76.00
76.01	03951	HOSPITAL NUTRITION	0.000000			76.01
76.02	03952	PAIN MANAGEMENT	0.000000			76.02
76.03	03954	INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/25/2020 9:55 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,519,061	0	3,519,061	3,838	916.90	30.00
31.00	INTENSIVE CARE UNIT	1,186,892		1,186,892	2,912	407.59	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
200.00	Total (lines 30 through 199)	4,705,953		4,705,953	6,750		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	868	795,869				30.00
31.00	INTENSIVE CARE UNIT	729	297,133				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
200.00	Total (lines 30 through 199)	1,597	1,093,002				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,197,561	88,258,288	0.036230	6,678,796	241,973	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,270,542	36,936,303	0.034398	1,458,116	50,156	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,639,368	61,588,652	0.042855	688,759	29,517	55.00
56.00	05600	RADIOISOTOPE	163,181	22,140,664	0.007370	49,869	368	56.00
57.00	05700	CT SCAN	130,697	68,628,836	0.001904	889,959	1,694	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	148,754	18,310,594	0.008124	304,711	2,475	58.00
60.00	06000	LABORATORY	1,009,776	60,285,054	0.016750	2,874,502	48,148	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	182,640	7,367,278	0.024791	839,168	20,804	63.00
64.00	06400	INTRAVENOUS THERAPY	825,265	22,456,993	0.036749	18,613	684	64.00
65.00	06500	RESPIRATORY THERAPY	92,641	5,809,592	0.015946	811,398	12,939	65.00
66.00	06600	PHYSICAL THERAPY	350,362	3,188,110	0.109896	425,363	46,746	66.00
69.00	06900	ELECTROCARDIOLOGY	83,618	4,698,230	0.017798	274,602	4,887	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	588,231	4,575,861	0.128551	733,886	94,342	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,630,330	574,311,846	0.004580	12,475,331	57,137	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	64,415	861,908	0.074735	38,154	2,851	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,677,333	11,591,030	0.230983	33,981	7,849	90.00
91.00	09100	EMERGENCY	227,961	2,267,047	0.100554	291,834	29,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	718,850	2,063,748	0.348323	171,719	59,814	92.00
200.00		Total (lines 50 through 199)	17,001,525	995,340,034		29,058,761	711,729	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0100		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/25/2020 9:55 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0	0	0	0	34.00
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	3,838	0.00		868	30.00
31.00	03100	INTENSIVE CARE UNIT			0	2,912	0.00		729	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			0	0	0.00		0	34.00
200.00		Total (lines 30 through 199)			0	6,750			1,597	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0						34.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0100

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 9:55 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	88,258,288	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,936,303	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	61,588,652	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	22,140,664	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	68,628,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	18,310,594	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	60,285,054	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,367,278	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	22,456,993	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,809,592	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,188,110	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,698,230	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,575,861	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	574,311,846	0.000000	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	861,908	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,591,030	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,267,047	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,063,748	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	995,340,034		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 9:55 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	6,678,796		0	11,124,905	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	1,458,116		0	9,481,229	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	688,759		0	17,977,292	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	49,869		0	3,725,018	0	56.00
57.00	05700	CT SCAN		0.000000	889,959		0	16,912,881	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	304,711		0	4,090,935	0	58.00
60.00	06000	LABORATORY		0.000000	2,874,502		0	10,529,413	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	839,168		0	570,170	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	18,613		0	5,470,928	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	811,398		0	840,527	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	425,363		0	70,063	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	274,602		0	998,182	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	733,886		0	324,284	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	12,475,331		0	132,180,552	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE		0.000000	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION		0.000000	38,154		0	5,050	0	76.01
76.02	03952	PAIN MANAGEMENT		0.000000	0		0	0	0	76.02
76.03	03954	INFUSION CENTER		0.000000	0		0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	33,981		0	2,756,726	0	90.00
91.00	09100	EMERGENCY		0.000000	291,834		0	329,100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	171,719		0	283,598	0	92.00
200.00		Total (lines 50 through 199)			29,058,761		0	217,670,853	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 9:55 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.244665	11,124,905	0	0	2,721,875	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238451	9,481,229	0	0	2,260,809	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.167673	17,977,292	0	0	3,014,306	55.00
56.00	05600	RADIOISOTOPE	0.295025	3,725,018	0	0	1,098,973	56.00
57.00	05700	CT SCAN	0.029330	16,912,881	0	0	496,055	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090935	4,090,935	0	0	372,009	58.00
60.00	06000	LABORATORY	0.163130	10,529,413	0	0	1,717,663	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.268507	570,170	0	0	153,095	63.00
64.00	06400	INTRAVENOUS THERAPY	0.205906	5,470,928	0	0	1,126,497	64.00
65.00	06500	RESPIRATORY THERAPY	0.395817	840,527	0	0	332,695	65.00
66.00	06600	PHYSICAL THERAPY	0.836536	70,063	0	0	58,610	66.00
69.00	06900	ELECTROCARDIOLOGY	0.166812	998,182	0	0	166,509	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548406	324,284	0	0	177,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176127	132,180,552	501	404,339	23,280,564	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.995206	5,050	0	0	5,026	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.436418	2,756,726	0	498	3,959,811	90.00
91.00	09100	EMERGENCY	0.876696	329,100	0	0	288,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.388530	283,598	0	0	393,784	92.00
200.00		Subtotal (see instructions)		217,670,853	501	404,837	41,624,641	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		217,670,853	501	404,837	41,624,641	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 9:55 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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 PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88	71,215		73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	715		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)	88	71,930		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	88	71,930		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 9:55 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)		3,838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,838	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,054	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)		868	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		145.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		145.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,028,157	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)		14,028,157	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)		14,028,157	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)		3,655.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,172,601	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)		3,172,601	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,218,233	2,912	1,448.57	729	1,056,008	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						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)					6,767,422	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,996,031	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)					1,093,002	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					711,729	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,804,731	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,191,300	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)					784	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,655.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,865,575	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 9:55 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	3,519,061	14,028,157	0.250857	2,865,575	718,850	90.00
91.00 Nursing School cost	0	14,028,157	0.000000	2,865,575	0	91.00
92.00 Allied health cost	0	14,028,157	0.000000	2,865,575	0	92.00
93.00 All other Medical Education	0	14,028,157	0.000000	2,865,575	0	93.00

Health Financial Systems		MIDWESTERN REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 9:55 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,717,400	30.00
31.00	03100	INTENSIVE CARE UNIT		1,729,141	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244665	6,678,796	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238451	1,458,116	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.167673	688,759	55.00
56.00	05600	RADIOISOTOPE	0.295025	49,869	56.00
57.00	05700	CT SCAN	0.029330	889,959	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.090935	304,711	58.00
60.00	06000	LABORATORY	0.163130	2,874,502	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.268507	839,168	63.00
64.00	06400	INTRAVENOUS THERAPY	0.205906	18,613	64.00
65.00	06500	RESPIRATORY THERAPY	0.395817	811,398	65.00
66.00	06600	PHYSICAL THERAPY	0.836536	425,363	66.00
69.00	06900	ELECTROCARDIOLOGY	0.166812	274,602	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548406	733,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176127	12,475,331	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	0.995206	38,154	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.436418	33,981	90.00
91.00	09100	EMERGENCY	0.876696	291,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.388530	171,719	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		29,058,761	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)		29,058,761	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/25/2020 9:55 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		890,087	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,319,128	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)		628,981	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		2,063,276	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)		70.86	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/25/2020 9:55 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	5,901,472			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		5,901,472		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		898,838		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		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)		6,800,310		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,800,310		61.00
62.00	Deductibles billed to program beneficiaries		250,272		62.00
63.00	Coinsurance billed to program beneficiaries		3,751		63.00
64.00	Allowable bad debts (see instructions)		21,397		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		13,908		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,560,195		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)				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)		19,844		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A
Date/Time Prepared:
11/25/2020 9:55 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			68,201	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			6,511,838	71.00
71.01	Sequestration adjustment (see instructions)			108,748	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			0	71.03
72.00	Interim payments			6,400,550	72.00
72.01	Interim payments-PARHM			0	72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			2,540	74.00
74.01	Balance due provider/program-PARHM (see instructions)			0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/25/2020 9:55 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	890,087	890,087		890,087	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,319,128		2,319,128	2,319,128	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	628,981	628,981		628,981	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	2,063,276		2,063,276	2,063,276	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,901,472	1,519,068	4,382,404	5,901,472	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,901,472	1,519,068	4,382,404	5,901,472	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	898,838	233,170	665,668	898,838	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,752,238	5,048,072	6,800,310	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/25/2020 9:55 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	257,370	72,413	184,957	257,370	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	641,468	160,757	480,711	641,468	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	898,838	233,170	665,668	898,838	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	19,844	4,988	14,856	19,844	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		17,572	50,629	68,201	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 9:55 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		72,018	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		41,624,641	2.00
3.00	OPPS payments		25,676,879	3.00
4.00	Outlier payment (see instructions)		1,557,475	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		72,018	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		405,338	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)		405,338	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)		405,338	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		333,320	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)		72,018	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)		27,234,354	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,942,298	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)		23,364,074	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)		23,364,074	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		23,364,074	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)		501,141	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		325,742	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		23,689,816	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)		23,689,816	40.00
40.01	Sequestration adjustment (see instructions)		395,620	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		23,294,060	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)		136	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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/25/2020 9:55 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,396,889		23,208,316	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	02/20/2020	3,661	02/20/2020	85,744	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)		3,661		85,744	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)		6,400,550		23,294,060	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		2,540		136	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,403,090		23,294,196	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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/25/2020 9:55 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

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

Provider CCN: 14-0100

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

Worksheet G

Date/Time Prepared:
11/25/2020 9:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	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	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	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	0	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	0	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	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	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)	0	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0100

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

Worksheet G-1

Date/Time Prepared:
11/25/2020 9:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-361,226,006				2.00
3.00	Total (sum of line 1 and line 2)		-361,226,006		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)		-361,226,006		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)		-361,226,006		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: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2020 9:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	0		0	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		361,226,006		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)		361,226,006		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0100

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

Worksheet G-3

Date/Time Prepared:
11/25/2020 9:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	361,226,006	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-361,226,006	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	OTHER (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-361,226,006	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-361,226,006	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0100

Period:
From 07/01/2019
To 06/30/2020Worksheet L
Parts I-III
Date/Time Prepared:
11/25/2020 9:55 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	257,370	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	641,468	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)	16.30	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	898,838	12.00
			1.00
PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
			1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00