

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: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2021 2:21 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2021	Time: 2:21 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRIS HOSPITAL (14-0101) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHAEL LAWRENCE
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
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	419,138	293,722	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	419,138	293,722	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: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 2:21 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 150 WEST HIGH STREET			PO Box:				1.00			
2.00	City: MORRIS			State: IL		Zip Code: 60450		County: GRUNDY			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MORRIS HOSPITAL	140101	16974	1	07/01/1966	O	P	P	
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF		MORRIS HOSPITAL	14U101	16974		10/07/1994	N	N	N	
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020		12/31/2020		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	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.			444	169	16	0	1,334	84		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0101

Period:
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To 12/31/2020Worksheet S-2
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2020
To 12/31/2020Worksheet S-2
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 2:21 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,715,445	50,000	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.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2021 2:21 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							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	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 7/28/2021 2:21 pm	
				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)			N			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	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
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	03/02/2021	Y	03/02/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	CHRISTOPHER	WALSKI		41.00
42.00	Enter the employer/company name of the cost report preparer.	PLANTE MORAN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	231-932-5664	CHRISTOPHER.WALSKI@PLANTEMORAN.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
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		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.	CPA	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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	81	29,646	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)		81	29,646	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		89	32,574	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)		89			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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,497	329	10,920			1.00
2.00	HMO and other (see instructions)	1,347	1,519				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,497	329	10,920			7.00
8.00	INTENSIVE CARE UNIT	1,159	16	2,619			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		99	837			13.00
14.00	Total (see instructions)	7,656	444	14,376	0.00	1,074.45	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	1,074.45	27.00
28.00	Observation Bed Days		0	2,675			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			210			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	84	264			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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,702	97	3,482	1.00
2.00 HMO and other (see instructions)			287	391		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,702	97	3,482	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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	81,605,030	0	81,605,030	2,234,863.08	36.51
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		1,636,131	0	1,636,131	6,330.15	258.47
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		10,709,391	0	10,709,391	55,377.44	193.39
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,339,248	8,463	6,347,711	150,182.46	42.27
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		516,174	0	516,174	7,774.35	66.39
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		0	0	0	0.00	0.00
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)		19,641,153	0	19,641,153		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,458,129	0	1,458,129		
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		61,460	0	61,460		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		537,663	0	537,663		
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)		0	0	0		
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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	456,084	0	456,084	15,101.78	30.20	26.00
27.00	Administrative & General	5.00	11,543,013	49,923	11,592,936	371,810.08	31.18	27.00
28.00	Administrative & General under contract (see inst.)		1,083,960	0	1,083,960	7,398.59	146.51	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,165,397	0	1,165,397	42,094.07	27.69	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,581,596	0	1,581,596	102,467.60	15.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,274,447	-842,510	431,937	24,919.85	17.33	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	784,124	784,124	45,238.60	17.33	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,950,626	0	1,950,626	59,588.32	32.74	38.00
39.00	Central Services and Supply	14.00	762,810	0	762,810	39,144.27	19.49	39.00
40.00	Pharmacy	15.00	2,220,594	0	2,220,594	45,356.54	48.96	40.00
41.00	Medical Records & Medical Records Library	16.00	1,556,344	0	1,556,344	66,722.17	23.33	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/28/2021 2:21 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	71,979,599	0	71,979,599	2,186,884.23	32.91	1.00
2.00	Excluded area salaries (see instructions)	6,339,248	8,463	6,347,711	150,182.46	42.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)	65,640,351	-8,463	65,631,888	2,036,701.77	32.22	3.00
4.00	Subtotal other wages & related costs (see inst.)	516,174	0	516,174	7,774.35	66.39	4.00
5.00	Subtotal wage-related costs (see inst.)	19,702,613	0	19,702,613	0.00	30.02	5.00
6.00	Total (sum of lines 3 thru 5)	85,859,138	-8,463	85,850,675	2,044,476.12	41.99	6.00
7.00	Total overhead cost (see instructions)	23,594,871	-8,463	23,586,408	819,841.87	28.77	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	590,781	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)	14,523,219	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	368,335	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	104,587	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	83,953	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	395,363	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	5,444,735	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	68,570	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	20,010	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	98,852	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,698,405	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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	516,174	21,698,405	1.00
2.00	Hospital	516,174	21,698,405	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: 14-0101

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

Worksheet S-10

Date/Time Prepared:
7/28/2021 2:21 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.237800	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		6,907,407	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,640,571	5.00
6.00	Medicaid charges		84,545,988	6.00
7.00	Medicaid cost (line 1 times line 6)		20,105,036	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)		11,557,058	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)		11,557,058	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,453,255	1,939,062	8,392,317
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,534,584	1,939,062	3,473,646
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,534,584	1,939,062	3,473,646
			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)		8,851,438	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		517,733	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		796,512	27.01
28.00	Non-Medicare bad debt expense (see instructions)		8,054,926	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,194,240	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,667,886	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		17,224,944	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0101

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

Worksheet A

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,968,427	3,968,427	1,186,885	5,155,312	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,030,625	5,030,625	0	5,030,625	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	456,084	22,384,979	22,841,063	0	22,841,063	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,543,013	20,731,230	32,274,243	78,959	32,353,202	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,165,397	2,971,494	4,136,891	0	4,136,891	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	338,645	338,645	0	338,645	8.00
9.00	00900	HOUSEKEEPING	1,581,596	676,037	2,257,633	0	2,257,633	9.00
10.00	01000	DIETARY	1,274,447	741,257	2,015,704	-1,332,538	683,166	10.00
11.00	01100	CAFETERIA	0	0	0	1,240,194	1,240,194	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,950,626	333,375	2,284,001	0	2,284,001	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	762,810	318,252	1,081,062	0	1,081,062	14.00
15.00	01500	PHARMACY	2,220,594	8,069,797	10,290,391	0	10,290,391	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,556,344	157,531	1,713,875	0	1,713,875	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,279,640	1,233,691	10,513,331	-222,203	10,291,128	30.00
31.00	03100	INTENSIVE CARE UNIT	3,388,063	565,507	3,953,570	-930,388	3,023,182	31.00
43.00	04300	NURSERY	0	0	0	649,669	649,669	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,222,821	994,513	4,217,334	0	4,217,334	50.00
51.00	05100	RECOVERY ROOM	390,179	15,603	405,782	0	405,782	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	502,922	502,922	52.00
53.00	05300	ANESTHESIOLOGY	0	64,678	64,678	0	64,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,458,529	885,685	3,344,214	0	3,344,214	54.00
54.01	05401	NUCLEAR MEDICINE	305,637	414,509	720,146	0	720,146	54.01
54.02	05402	ULTRASOUND	798,004	22,261	820,265	0	820,265	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	762,453	971,705	1,734,158	0	1,734,158	55.00
57.00	05700	CT SCAN	726,860	270,056	996,916	0	996,916	57.00
58.00	05800	MRI	457,519	171,334	628,853	0	628,853	58.00
59.00	05900	CARDIAC CATHETERIZATION	845,938	478,150	1,324,088	0	1,324,088	59.00
59.97	05901	CARDIAC REHAB	223,017	12,537	235,554	0	235,554	59.97
60.00	06000	LABORATORY	3,691,532	5,629,600	9,321,132	0	9,321,132	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	947,051	320,678	1,267,729	0	1,267,729	65.00
66.00	06600	PHYSICAL THERAPY	1,358,828	49,395	1,408,223	0	1,408,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	840,573	125,880	966,453	0	966,453	67.00
68.00	06800	SPEECH PATHOLOGY	166,924	1,932	168,856	0	168,856	68.00
69.00	06900	ELECTROCARDIOLOGY	892,377	148,317	1,040,694	0	1,040,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,448,229	4,448,229	0	4,448,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,790,613	5,790,613	0	5,790,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	18,469,520	2,790,223	21,259,743	0	21,259,743	90.00
91.00	09100	EMERGENCY	3,529,406	1,257,815	4,787,221	0	4,787,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,186,885	1,186,885	-1,186,885	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,265,782	93,571,445	168,837,227	-13,385	168,823,842	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	13,385	13,385	190.01
191.01	19101	PATIENT TRANSPORTATION	209,974	67,405	277,379	0	277,379	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,992,993	1,953,752	7,946,745	0	7,946,745	192.00
193.00	19300	NONPAID WORKERS	126,326	7,940	134,266	0	134,266	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	9,955	612	10,567	0	10,567	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	81,605,030	95,601,154	177,206,184	0	177,206,184	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0101

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

Worksheet A

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,186,885	3,968,427	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,030,625	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-593,660	22,247,403	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,744,486	25,608,716	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,136,891	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	338,645	8.00
9.00	00900	HOUSEKEEPING	0	2,257,633	9.00
10.00	01000	DIETARY	0	683,166	10.00
11.00	01100	CAFETERIA	-283,305	956,889	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-4,440	2,279,561	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	341	1,081,403	14.00
15.00	01500	PHARMACY	-6,139	10,284,252	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-19,608	1,694,267	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,595,860	8,695,268	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,023,182	31.00
43.00	04300	NURSERY	0	649,669	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,217,334	50.00
51.00	05100	RECOVERY ROOM	0	405,782	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	502,922	52.00
53.00	05300	ANESTHESIOLOGY	0	64,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,344,214	54.00
54.01	05401	NUCLEAR MEDICINE	0	720,146	54.01
54.02	05402	ULTRASOUND	0	820,265	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	-339,713	1,394,445	55.00
57.00	05700	CT SCAN	0	996,916	57.00
58.00	05800	MRI	0	628,853	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,324,088	59.00
59.97	05901	CARDIAC REHAB	0	235,554	59.97
60.00	06000	LABORATORY	-372,427	8,948,705	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,267,729	65.00
66.00	06600	PHYSICAL THERAPY	0	1,408,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	967,788	67.00
68.00	06800	SPEECH PATHOLOGY	0	168,856	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,040,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,448,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,790,613	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-10,482,938	10,776,805	90.00
91.00	09100	EMERGENCY	-879,814	3,907,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,507,599	146,316,243	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19001	MEALS ON WHEELS	-9,220	4,165	190.01
191.01	19101	PATIENT TRANSPORTATION	0	277,379	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	7,946,745	192.00
193.00	19300	NONPAID WORKERS	0	134,266	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	10,567	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-22,516,819	154,689,365	200.00

RECLASSIFICATIONS

Provider CCN: 14-0101

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 2:21 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA FOOD SERVICE					
1.00	CAFETERIA	11.00	784,124	456,070	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	49,923	29,036	2.00
3.00	MEALS ON WHEELS	190.01	8,463	4,922	3.00
	0		842,510	490,028	
G - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,186,885	1.00
	0		0	1,186,885	
J - LDR & NURSERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	472,629	30,293	1.00
2.00	NURSERY	43.00	610,537	39,132	2.00
	0		1,083,166	69,425	
K - POST ICU RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	797,308	133,080	1.00
	0		797,308	133,080	
500.00	Grand Total: Increases		2,722,984	1,879,418	500.00

RECLASSIFICATIONS

Provider CCN: 14-0101

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

Worksheet A-6

Date/Time Prepared:
7/28/2021 2:21 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA FOOD SERVICE					
1.00	DIETARY	10.00	842,510	490,028	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		842,510	490,028		
	G - INTEREST RECLASS					
1.00	INTEREST EXPENSE	113.00	0	1,186,885	11	1.00
	0		0	1,186,885		
	J - LDR & NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	1,083,166	69,425	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,083,166	69,425		
	K - POST ICU RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	797,308	133,080	0	1.00
	0		797,308	133,080		
500.00	Grand Total: Decreases		2,722,984	1,879,418		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	10,231,303	651,345	0	651,345	0	1.00
2.00	Land Improvements	7,334,943	232,168	0	232,168	0	2.00
3.00	Buildings and Fixtures	112,829,296	15,122,015	0	15,122,015	4,474,466	3.00
4.00	Building Improvements	2,342,649	0	0	0	0	4.00
5.00	Fixed Equipment	26,000,571	2,082,300	0	2,082,300	0	5.00
6.00	Movable Equipment	78,663,677	4,412,552	0	4,412,552	304,480	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	237,402,439	22,500,380	0	22,500,380	4,778,946	8.00
9.00	Reconciling Items	30,396,341	0	0	0	4,435,693	9.00
10.00	Total (line 8 minus line 9)	207,006,098	22,500,380	0	22,500,380	343,253	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	10,882,648	0				1.00
2.00	Land Improvements	7,567,111	0				2.00
3.00	Buildings and Fixtures	123,476,845	0				3.00
4.00	Building Improvements	2,342,649	0				4.00
5.00	Fixed Equipment	28,082,871	0				5.00
6.00	Movable Equipment	82,771,749	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	255,123,873	0				8.00
9.00	Reconciling Items	25,960,648	0				9.00
10.00	Total (line 8 minus line 9)	229,163,225	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,966,031	0	0	2,396	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,030,625	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,996,656	0	0	2,396	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,968,427				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,030,625				2.00
3.00	Total (sum of lines 1-2)	0	8,999,052				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	148,743,719	0	148,743,719	0.572305	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	111,159,100	0	111,159,100	0.427695	0	2.00
3.00	Total (sum of lines 1-2)	259,902,819	0	259,902,819	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	3,966,031	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,030,625	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,996,656	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,396	0	0	3,968,427	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,030,625	2.00
3.00	Total (sum of lines 1-2)	0	2,396	0	0	8,999,052	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0101

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-1,186,885	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
4.00	Investment income - other (chapter 2)		0		0.00	0	3.00
5.00	Trade, quantity, and time discounts (chapter 8)	B	828	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
6.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
7.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
8.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
9.00	Television and radio service (chapter 21)		0		0.00	0	8.00
10.00	Parking lot (chapter 21)		0		0.00	0	9.00
11.00	Provider-based physician adjustment	A-8-2	-14,788,366			0	10.00
12.00	Sale of scrap, waste, etc. (chapter 23)	B	-487	CENTRAL SERVICES & SUPPLY	14.00	0	11.00
13.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
14.00	Laundry and linen service		0		0.00	0	13.00
15.00	Cafeteria-employees and guests	B	-283,305	CAFETERIA	11.00	0	14.00
16.00	Rental of quarters to employee and others		0		0.00	0	15.00
17.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
18.00	Sale of drugs to other than patients	B	-6,139	PHARMACY	15.00	0	17.00
19.00	Sale of medical records and abstracts	B	-19,608	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-144,436	EMERGENCY	91.00	0	19.00
21.00	Vending machines		0		0.00	0	20.00
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
26.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
29.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
30.00	Physicians' assistant		0		0.00	0	29.00
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
32.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
33.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
	LIFELINE SALARIES AND BENEFITS	A	-102,271	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0101

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

Worksheet A-8

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
35.00	LOBBYING COSTS	A	-31,366	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	MARKETING	A	-262,669	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MISC INCOME	B	-5,343	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	EDUCATION SERVICES	B	-12,917	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	VOLUNTEER SERVICES	B	-165	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MEALS ON WHEELS	B	-9,220	MEALS ON WHEELS	190.01	0	40.00
41.00	MEDICAID PROVIDER TAXES	A	-5,070,810	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	PHYSICIAN FRINGE BENEFITS	A	-593,660	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,516,819				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0101

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2021 2:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,258,945	1,258,945	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	4,440	4,440	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,595,860	1,595,860	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	339,713	339,713	0	0	0	4.00
5.00	60.00	LABORATORY	372,427	372,427	0	0	0	5.00
6.00	67.00	OCCUPATIONAL THERAPY	-1,335	-1,335	0	0	0	6.00
7.00	90.00	CLINIC	10,482,938	10,482,938	0	0	0	7.00
8.00	91.00	EMERGENCY	735,378	735,378	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			14,788,366	14,788,366	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,258,945		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	4,440		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,595,860		3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	339,713		4.00
5.00	60.00	LABORATORY	0	0	0	372,427		5.00
6.00	67.00	OCCUPATIONAL THERAPY	0	0	0	-1,335		6.00
7.00	90.00	CLINIC	0	0	0	10,482,938		7.00
8.00	91.00	EMERGENCY	0	0	0	735,378		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	14,788,366		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,968,427	3,968,427			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,030,625		5,030,625		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,247,403	33,188	42,072	22,322,663	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,608,716	617,318	782,556	3,630,552	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,136,891	589,925	747,825	370,178	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	338,645	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,257,633	106,555	135,076	502,380	9.00
10.00	01000	DIETARY	683,166	72,926	92,446	137,201	10.00
11.00	01100	CAFETERIA	956,889	44,474	56,378	249,070	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,279,561	18,293	23,190	619,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,081,403	44,034	55,820	242,300	14.00
15.00	01500	PHARMACY	10,284,252	53,242	67,493	705,352	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,694,267	85,850	108,828	494,359	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,695,268	356,691	452,164	2,853,382	30.00
31.00	03100	INTENSIVE CARE UNIT	3,023,182	121,556	154,091	822,930	31.00
43.00	04300	NURSERY	649,669	11,057	14,016	193,932	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,217,334	277,180	351,370	1,023,700	50.00
51.00	05100	RECOVERY ROOM	405,782	56,447	71,555	123,937	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	502,922	63,507	80,505	150,126	52.00
53.00	05300	ANESTHESIOLOGY	64,678	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,344,214	183,971	233,213	780,930	54.00
54.01	05401	NUCLEAR MEDICINE	720,146	23,417	29,684	97,083	54.01
54.02	05402	ULTRASOUND	820,265	5,194	6,584	253,479	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,394,445	58,507	74,167	148,097	55.00
57.00	05700	CT SCAN	996,916	44,685	56,646	230,881	57.00
58.00	05800	MRI	628,853	40,530	51,379	145,327	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,324,088	36,974	46,870	268,705	59.00
59.97	05901	CARDIAC REHAB	235,554	0	0	70,839	59.97
60.00	06000	LABORATORY	8,948,705	170,220	215,782	1,054,284	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,267,729	29,421	37,295	300,822	65.00
66.00	06600	PHYSICAL THERAPY	1,408,223	32,836	41,625	431,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	967,788	405	513	267,000	67.00
68.00	06800	SPEECH PATHOLOGY	168,856	0	0	53,022	68.00
69.00	06900	ELECTROCARDIOLOGY	1,040,694	68,542	86,888	283,456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,448,229	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,790,613	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,776,805	548,638	695,487	2,680,735	90.00
91.00	09100	EMERGENCY	3,907,407	149,022	188,909	1,121,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	146,316,243	3,944,605	5,000,427	20,306,361	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	MEALS ON WHEELS	4,165	0	0	2,688	190.01
191.01	19101	PATIENT TRANSPORTATION	277,379	23,822	30,198	66,696	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	7,946,745	0	0	1,903,630	192.00
193.00	19300	NONPAID WORKERS	134,266	0	0	40,126	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	10,567	0	0	3,162	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	154,689,365	3,968,427	5,030,625	22,322,663	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,639,142					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,443,612	0	7,288,431			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,642	0	0	422,287		8.00
9.00	00900	HOUSEKEEPING	741,376	0	284,684	0	4,027,704	9.00
10.00	01000	DIETARY	243,468	0	194,839	0	112,047	10.00
11.00	01100	CAFETERIA	322,769	0	118,822	0	68,332	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	726,309	0	48,874	0	28,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	351,604	0	117,646	0	67,656	14.00
15.00	01500	PHARMACY	2,744,143	0	142,248	0	81,804	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	588,652	0	229,366	0	131,903	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,052,180	0	952,978	320,769	548,037	30.00
31.00	03100	INTENSIVE CARE UNIT	1,018,033	0	324,762	76,932	186,764	31.00
43.00	04300	NURSERY	214,554	0	29,541	24,586	16,988	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,449,729	0	740,547	0	425,872	50.00
51.00	05100	RECOVERY ROOM	162,451	0	150,809	0	86,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196,866	0	169,672	0	97,575	52.00
53.00	05300	ANESTHESIOLOGY	15,975	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,121,910	0	491,518	0	282,662	54.00
54.01	05401	NUCLEAR MEDICINE	214,963	0	62,563	0	35,979	54.01
54.02	05402	ULTRASOUND	268,113	0	13,877	0	7,980	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	413,762	0	156,313	0	89,892	55.00
57.00	05700	CT SCAN	328,281	0	119,387	0	68,657	57.00
58.00	05800	MRI	213,915	0	108,285	0	62,273	58.00
59.00	05900	CARDIAC CATHETERIZATION	414,113	0	98,783	0	56,808	59.00
59.97	05901	CARDIAC REHAB	75,676	0	0	0	0	59.97
60.00	06000	LABORATORY	2,565,977	0	454,780	0	261,534	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	403,895	0	78,603	0	45,203	65.00
66.00	06600	PHYSICAL THERAPY	472,814	0	87,729	0	50,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	305,207	0	1,082	0	622	67.00
68.00	06800	SPEECH PATHOLOGY	54,802	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	365,441	0	183,126	0	105,312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,098,668	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,430,224	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,631,139	0	1,465,808	0	842,954	90.00
91.00	09100	EMERGENCY	1,325,453	0	398,144	0	228,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,059,716	0	7,224,786	422,287	3,991,103	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	1,693	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	98,325	0	63,645	0	36,601	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,432,944	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	43,073	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	3,391	0	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)	30,639,142	0	7,288,431	422,287	4,027,704	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,536,093					10.00
11.00	01100	CAFETERIA	0	1,816,734				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	105,582	0	3,849,515		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,922	0	246	1,971,631	14.00
15.00	01500	PHARMACY	0	80,096	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,238,949	422,330	0	1,363,429	0	30.00
31.00	03100	INTENSIVE CARE UNIT	297,144	123,785	0	705,700	0	31.00
43.00	04300	NURSERY	0	29,126	0	105,643	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	152,911	0	553,790	0	50.00
51.00	05100	RECOVERY ROOM	0	14,563	0	85,649	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,844	0	81,780	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112,863	0	94,948	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	10,922	0	0	0	54.01
54.02	05402	ULTRASOUND	0	21,844	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	29,126	0	21,163	0	55.00
57.00	05700	CT SCAN	0	29,126	0	0	0	57.00
58.00	05800	MRI	0	18,204	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	36,407	0	85,865	0	59.00
59.97	05901	CARDIAC REHAB	0	10,922	0	51,934	0	59.97
60.00	06000	LABORATORY	0	207,523	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	47,330	0	21,543	0	65.00
66.00	06600	PHYSICAL THERAPY	0	61,893	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,126	0	23,206	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,281	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,689	0	62,690	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	856,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,115,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	174,756	0	591,929	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,536,093	1,802,171	0	3,849,515	1,971,631	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	14,563	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	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)	1,536,093	1,816,734	0	3,849,515	1,971,631	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			15.00	16.00	17.00	19.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	14,158,630					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,333,225				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	155,983	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,911	0	0	0	31.00
43.00	04300	NURSERY	0	7,275	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	207,386	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	23,216	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,632	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	46,136	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,386	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	53,115	0	0	0	54.01
54.02	05402	ULTRASOUND	0	102,213	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	71,992	0	0	0	55.00
57.00	05700	CT SCAN	0	403,091	0	0	0	57.00
58.00	05800	MRI	0	90,535	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	106,757	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0	4,027	0	0	0	59.97
60.00	06000	LABORATORY	0	685,723	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	49,816	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	45,648	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,561	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,195	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	121,907	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	146,806	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	87,477	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,158,630	214,580	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	151,768	0	0	0	90.00
91.00	09100	EMERGENCY	0	349,089	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,158,630	3,333,225	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	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)	14,158,630	3,333,225	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	20,412,160	0	20,412,160	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,908,790	0	6,908,790	31.00
43.00	04300	NURSERY	0	0	1,296,387	0	1,296,387	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	9,399,819	0	9,399,819	50.00
51.00	05100	RECOVERY ROOM	0	0	1,181,136	0	1,181,136	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,370,429	0	1,370,429	52.00
53.00	05300	ANESTHESIOLOGY	0	0	126,789	0	126,789	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,775,615	0	6,775,615	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	1,247,872	0	1,247,872	54.01
54.02	05402	ULTRASOUND	0	0	1,499,549	0	1,499,549	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	2,457,464	0	2,457,464	55.00
57.00	05700	CT SCAN	0	0	2,277,670	0	2,277,670	57.00
58.00	05800	MRI	0	0	1,359,301	0	1,359,301	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,475,370	0	2,475,370	59.00
59.97	05901	CARDIAC REHAB	0	0	448,952	0	448,952	59.97
60.00	06000	LABORATORY	0	0	14,564,528	0	14,564,528	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	2,281,657	0	2,281,657	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,632,838	0	2,632,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,610,510	0	1,610,510	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	288,156	0	288,156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,361,745	0	2,361,745	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,550,272	0	6,550,272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,423,376	0	8,423,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,373,210	0	14,373,210	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	20,793,334	0	20,793,334	90.00
91.00	09100	EMERGENCY	0	0	8,434,757	0	8,434,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	141,551,686	0	141,551,686	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	8,546	0	8,546	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	611,229	0	611,229	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	12,283,319	0	12,283,319	192.00
193.00	19300	NONPAID WORKERS	0	0	217,465	0	217,465	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	17,120	0	17,120	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	154,689,365	0	154,689,365	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,188	42,072	75,260	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	949,853	617,318	782,556	2,349,727	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	42,532	589,925	747,825	1,380,282	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,321	106,555	135,076	244,952	9.00
10.00	01000	DIETARY	4,619	72,926	92,446	169,991	10.00
11.00	01100	CAFETERIA	0	44,474	56,378	100,852	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	78,122	18,293	23,190	119,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-22,527	44,034	55,820	77,327	14.00
15.00	01500	PHARMACY	216,371	53,242	67,493	337,106	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	85,850	108,828	194,678	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	744	356,691	452,164	809,599	30.00
31.00	03100	INTENSIVE CARE UNIT	194	121,556	154,091	275,841	31.00
43.00	04300	NURSERY	0	11,057	14,016	25,073	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	218,592	277,180	351,370	847,142	50.00
51.00	05100	RECOVERY ROOM	0	56,447	71,555	128,002	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	63,507	80,505	144,012	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,108	183,971	233,213	418,292	54.00
54.01	05401	NUCLEAR MEDICINE	188	23,417	29,684	53,289	54.01
54.02	05402	ULTRASOUND	275	5,194	6,584	12,053	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	326,939	58,507	74,167	459,613	55.00
57.00	05700	CT SCAN	2,330	44,685	56,646	103,661	57.00
58.00	05800	MRI	82	40,530	51,379	91,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,687	36,974	46,870	85,531	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	59.97
60.00	06000	LABORATORY	75,021	170,220	215,782	461,023	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	100,629	29,421	37,295	167,345	65.00
66.00	06600	PHYSICAL THERAPY	1,025	32,836	41,625	75,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	405	513	918	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	68,542	86,888	155,430	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	531,227	548,638	695,487	1,775,352	90.00
91.00	09100	EMERGENCY	2,568	149,022	188,909	340,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,534,900	3,944,605	5,000,427	11,479,932	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	MEALS ON WHEELS	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	78	23,822	30,198	54,098	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	222,642	0	0	222,642	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,757,620	3,968,427	5,030,625	11,756,672	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,361,961					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	111,285	0	1,492,815			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,448	0	0	6,448		8.00
9.00	00900	HOUSEKEEPING	57,151	0	58,309	0	362,106	9.00
10.00	01000	DIETARY	18,768	0	39,907	0	10,073	10.00
11.00	01100	CAFETERIA	24,882	0	24,337	0	6,143	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	55,990	0	10,010	0	2,527	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,105	0	24,096	0	6,083	14.00
15.00	01500	PHARMACY	211,541	0	29,135	0	7,354	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,378	0	46,979	0	11,859	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	235,287	0	195,189	4,898	49,271	30.00
31.00	03100	INTENSIVE CARE UNIT	78,478	0	66,518	1,175	16,791	31.00
43.00	04300	NURSERY	16,540	0	6,051	375	1,527	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	111,757	0	151,679	0	38,288	50.00
51.00	05100	RECOVERY ROOM	12,523	0	30,889	0	7,797	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,176	0	34,752	0	8,772	52.00
53.00	05300	ANESTHESIOLOGY	1,231	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,486	0	100,673	0	25,412	54.00
54.01	05401	NUCLEAR MEDICINE	16,571	0	12,814	0	3,235	54.01
54.02	05402	ULTRASOUND	20,668	0	2,842	0	717	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	31,896	0	32,016	0	8,082	55.00
57.00	05700	CT SCAN	25,307	0	24,453	0	6,173	57.00
58.00	05800	MRI	16,490	0	22,179	0	5,599	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,923	0	20,233	0	5,107	59.00
59.97	05901	CARDIAC REHAB	5,834	0	0	0	0	59.97
60.00	06000	LABORATORY	197,806	0	93,148	0	23,513	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	31,135	0	16,100	0	4,064	65.00
66.00	06600	PHYSICAL THERAPY	36,448	0	17,969	0	4,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,528	0	222	0	56	67.00
68.00	06800	SPEECH PATHOLOGY	4,225	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,171	0	37,508	0	9,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	84,694	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,253	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	279,967	0	300,223	0	75,783	90.00
91.00	09100	EMERGENCY	102,177	0	81,548	0	20,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,163,119	0	1,479,779	6,448	358,815	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	130	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	7,580	0	13,036	0	3,291	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	187,551	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	3,320	0	0	0	0	193.00
194.00	07950	YOUTH RADIOLOGY PROGRAM	261	0	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)	2,361,961	0	1,492,815	6,448	362,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	239,202					10.00
11.00	01100	CAFETERIA	0	157,054				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	9,127	0	199,348		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	944	0	13	136,385	14.00
15.00	01500	PHARMACY	0	6,924	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	192,930	36,511	0	70,605	0	30.00
31.00	03100	INTENSIVE CARE UNIT	46,272	10,701	0	36,545	0	31.00
43.00	04300	NURSERY	0	2,518	0	5,471	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,219	0	28,678	0	50.00
51.00	05100	RECOVERY ROOM	0	1,259	0	4,435	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,888	0	4,235	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,757	0	4,917	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	944	0	0	0	54.01
54.02	05402	ULTRASOUND	0	1,888	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,518	0	1,096	0	55.00
57.00	05700	CT SCAN	0	2,518	0	0	0	57.00
58.00	05800	MRI	0	1,574	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,147	0	4,447	0	59.00
59.97	05901	CARDIAC REHAB	0	944	0	2,689	0	59.97
60.00	06000	LABORATORY	0	17,940	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	4,092	0	1,116	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,351	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,518	0	1,202	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	629	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,777	0	3,246	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	59,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	77,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,107	0	30,653	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	239,202	155,795	0	199,348	136,385	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	1,259	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	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)	239,202	157,054	0	199,348	136,385	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			15.00	16.00	17.00	19.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	594,438					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	300,561				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	14,066	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,862	0			31.00
43.00	04300	NURSERY	0	656	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	18,702	0			50.00
51.00	05100	RECOVERY ROOM	0	2,094	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	508	0			52.00
53.00	05300	ANESTHESIOLOGY	0	4,160	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,668	0			54.00
54.01	05401	NUCLEAR MEDICINE	0	4,790	0			54.01
54.02	05402	ULTRASOUND	0	9,217	0			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,492	0			55.00
57.00	05700	CT SCAN	0	36,350	0			57.00
58.00	05800	MRI	0	8,164	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,627	0			59.00
59.97	05901	CARDIAC REHAB	0	363	0			59.97
60.00	06000	LABORATORY	0	61,816	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	4,492	0			65.00
66.00	06600	PHYSICAL THERAPY	0	4,116	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,403	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	378	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,993	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,239	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,889	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	594,438	19,350	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	13,686	0			90.00
91.00	09100	EMERGENCY	0	31,480	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	594,438	300,561	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0			190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0			191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
193.00	19300	NONPAID WORKERS	0	0	0			193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	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)	594,438	300,561	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			1,617,977	0	1,617,977	30.00
31.00	03100	INTENSIVE CARE UNIT			539,958	0	539,958	31.00
43.00	04300	NURSERY			58,865	0	58,865	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			1,212,917	0	1,212,917	50.00
51.00	05100	RECOVERY ROOM			187,417	0	187,417	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			209,849	0	209,849	52.00
53.00	05300	ANESTHESIOLOGY			5,391	0	5,391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			659,838	0	659,838	54.00
54.01	05401	NUCLEAR MEDICINE			91,970	0	91,970	54.01
54.02	05402	ULTRASOUND			48,240	0	48,240	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC			542,212	0	542,212	55.00
57.00	05700	CT SCAN			199,240	0	199,240	57.00
58.00	05800	MRI			146,487	0	146,487	58.00
59.00	05900	CARDIAC CATHETERIZATION			160,921	0	160,921	59.00
59.97	05901	CARDIAC REHAB			10,069	0	10,069	59.97
60.00	06000	LABORATORY			858,801	0	858,801	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			229,358	0	229,358	65.00
66.00	06600	PHYSICAL THERAPY			145,361	0	145,361	66.00
67.00	06700	OCCUPATIONAL THERAPY			30,747	0	30,747	67.00
68.00	06800	SPEECH PATHOLOGY			5,411	0	5,411	68.00
69.00	06900	ELECTROCARDIOLOGY			249,549	0	249,549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			157,183	0	157,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			195,277	0	195,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			613,788	0	613,788	73.00
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			2,454,050	0	2,454,050	90.00
91.00	09100	EMERGENCY			625,829	0	625,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM			0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	11,256,705	0	11,256,705	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS			139	0	139	190.01
191.01	19101	PATIENT TRANSPORTATION			79,489	0	79,489	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES			416,612	0	416,612	192.00
193.00	19300	NONPAID WORKERS			3,455	0	3,455	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM			272	0	272	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	11,756,672	0	11,756,672	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	225,395				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		225,395			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,885	1,885	70,276,474		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,062	35,062	11,429,825	-30,639,142	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	33,506	33,506	1,165,397	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	6,052	6,052	1,581,596	0	9.00
10.00	01000	DIETARY	4,142	4,142	431,938	0	10.00
11.00	01100	CAFETERIA	2,526	2,526	784,124	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,039	1,039	1,950,626	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,501	2,501	762,810	0	14.00
15.00	01500	PHARMACY	3,024	3,024	2,220,594	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,876	4,876	1,556,344	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,259	20,259	8,983,040	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,904	6,904	2,590,755	0	31.00
43.00	04300	NURSERY	628	628	610,537	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,743	15,743	3,222,821	0	50.00
51.00	05100	RECOVERY ROOM	3,206	3,206	390,179	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,607	3,607	472,629	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,449	10,449	2,458,529	0	54.00
54.01	05401	NUCLEAR MEDICINE	1,330	1,330	305,637	0	54.01
54.02	05402	ULTRASOUND	295	295	798,004	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	3,323	3,323	466,240	0	55.00
57.00	05700	CT SCAN	2,538	2,538	726,860	0	57.00
58.00	05800	MRI	2,302	2,302	457,519	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,100	2,100	845,938	0	59.00
59.97	05901	CARDIAC REHAB	0	0	223,017	0	59.97
60.00	06000	LABORATORY	9,668	9,668	3,319,105	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,671	1,671	947,051	0	65.00
66.00	06600	PHYSICAL THERAPY	1,865	1,865	1,358,828	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23	23	840,573	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	166,924	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,893	3,893	892,377	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	31,161	31,161	8,439,511	0	90.00
91.00	09100	EMERGENCY	8,464	8,464	3,529,406	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,042	224,042	63,928,734	-30,639,142	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	MEALS ON WHEELS	0	0	8,463	0	190.01
191.01	19101	PATIENT TRANSPORTATION	1,353	1,353	209,974	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	5,993,022	0	192.00
193.00	19300	NONPAID WORKERS	0	0	126,326	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	0	9,955	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)	3,968,427	5,030,625	22,322,663	30,639,142	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	17.606544	22.319151	0.317641		0.246990	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			75,260		2,361,961	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001071		0.019040	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: 14-0101

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	154,942			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	14,376		8.00
9.00	00900	HOUSEKEEPING	0	6,052	0	148,890	9.00
10.00	01000	DIETARY	0	4,142	0	4,142	13,539 10.00
11.00	01100	CAFETERIA	0	2,526	0	2,526	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	1,039	0	1,039	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,501	0	2,501	0 14.00
15.00	01500	PHARMACY	0	3,024	0	3,024	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,876	0	4,876	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	20,259	10,920	20,259	10,920 30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,904	2,619	6,904	2,619 31.00
43.00	04300	NURSERY	0	628	837	628	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,743	0	15,743	0 50.00
51.00	05100	RECOVERY ROOM	0	3,206	0	3,206	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,607	0	3,607	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,449	0	10,449	0 54.00
54.01	05401	NUCLEAR MEDICINE	0	1,330	0	1,330	0 54.01
54.02	05402	ULTRASOUND	0	295	0	295	0 54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,323	0	3,323	0 55.00
57.00	05700	CT SCAN	0	2,538	0	2,538	0 57.00
58.00	05800	MRI	0	2,302	0	2,302	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,100	0	2,100	0 59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0 59.97
60.00	06000	LABORATORY	0	9,668	0	9,668	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	1,671	0	1,671	0 65.00
66.00	06600	PHYSICAL THERAPY	0	1,865	0	1,865	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	23	0	23	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,893	0	3,893	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	31,161	0	31,161	0 90.00
91.00	09100	EMERGENCY	0	8,464	0	8,464	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	153,589	14,376	147,537	13,539 118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	MEALS ON WHEELS	0	0	0	0	0 190.01
191.01	19101	PATIENT TRANSPORTATION	0	1,353	0	1,353	0 191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	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)	0	7,288,431	422,287	4,027,704	1,536,093 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	47.039737	29.374444	27.051541	113.456902 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,492,815	6,448	362,106	239,202 204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.634670	0.448525	2.432037	17.667627	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: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (SQUARE FEET)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	499					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	29	0	375,067			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3	0	24	10,238,842		14.00
15.00	01500	PHARMACY	22	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	116	0	132,842	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	34	0	68,758	0	0	31.00
43.00	04300	NURSERY	8	0	10,293	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42	0	53,957	0	0	50.00
51.00	05100	RECOVERY ROOM	4	0	8,345	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6	0	7,968	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31	0	9,251	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	3	0	0	0	0	54.01
54.02	05402	ULTRASOUND	6	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	8	0	2,062	0	0	55.00
57.00	05700	CT SCAN	8	0	0	0	0	57.00
58.00	05800	MRI	5	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10	0	8,366	0	0	59.00
59.97	05901	CARDIAC REHAB	3	0	5,060	0	0	59.97
60.00	06000	LABORATORY	57	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	13	0	2,099	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8	0	2,261	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12	0	6,108	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,448,229	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,790,613	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	48	0	57,673	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	495	0	375,067	10,238,842	100	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	4	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	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)	1,816,734	0	3,849,515	1,971,631	14,158,630	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,640.749499	0.000000	10.263540	0.192564	141,586.300000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (SQUARE FEET)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	157,054	0	199,348	136,385	594,438	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	314.737475	0.000000	0.531500	0.013320	5,944.380000	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: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	595,254,850					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,854,131	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,627,031	0	0	0	0	31.00
43.00	04300	NURSERY	1,299,129	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,033,215	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	4,145,641	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,005,681	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,238,508	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,104,568	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	9,484,793	0	0	0	0	54.01
54.02	05402	ULTRASOUND	18,252,242	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	12,855,726	0	0	0	0	55.00
57.00	05700	CT SCAN	71,980,539	0	0	0	0	57.00
58.00	05800	MRI	16,166,966	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,063,692	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	719,095	0	0	0	0	59.97
60.00	06000	LABORATORY	122,486,977	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,895,755	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	8,151,455	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,778,772	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	749,098	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,769,046	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,215,397	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,620,938	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,317,802	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	27,101,413	0	0	0	0	90.00
91.00	09100	EMERGENCY	62,337,240	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	595,254,850	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	MEALS ON WHEELS	0	0	0	0	0	190.01
191.01	19101	PATIENT TRANSPORTATION	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	0	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)	3,333,225	0	0	0	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
						16.00	17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.005600	0.000000	0.000000	0.000000	0.000000	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	300,561	0	0	0	0	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000505	0.000000	0.000000	0.000000	0.000000	205.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	NUCLEAR MEDICINE	54.01
54.02	05402	ULTRASOUND	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
59.97	05901	CARDIAC REHAB	59.97
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPS	76.99
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
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			
190.01	19001	MEALS ON WHEELS	190.01
191.01	19101	PATIENT TRANSPORTATION	191.01
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	YOUTH CARDIOLOGY PROGRAM	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0101

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

Worksheet B-1

Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

MCRIF32 - 16.10.172.3

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,983,182		23,983,182			30.00	
31.00	03100	INTENSIVE CARE UNIT	9,627,031		9,627,031			31.00	
43.00	04300	NURSERY	1,299,129		1,299,129			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,809,669	29,223,546	37,033,215	0.253821	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,179,542	2,966,099	4,145,641	0.284910	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,005,681	0	1,005,681	1.362688	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,192,620	6,045,888	8,238,508	0.015390	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,768,131	17,336,437	23,104,568	0.293259	0.000000	54.00	
54.01	05401	NUCLEAR MEDICINE	988,755	8,496,038	9,484,793	0.131566	0.000000	54.01	
54.02	05402	ULTRASOUND	2,415,558	15,836,684	18,252,242	0.082157	0.000000	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,855,726	12,855,726	0.191157	0.000000	55.00	
57.00	05700	CT SCAN	14,118,312	57,862,227	71,980,539	0.031643	0.000000	57.00	
58.00	05800	MRI	2,403,961	13,763,005	16,166,966	0.084079	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	7,138,890	11,924,802	19,063,692	0.129847	0.000000	59.00	
59.97	05901	CARDIAC REHAB	1,089	718,006	719,095	0.624329	0.000000	59.97	
60.00	06000	LABORATORY	31,319,991	91,166,986	122,486,977	0.118907	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	7,183,819	1,711,936	8,895,755	0.256488	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	2,695,589	5,455,866	8,151,455	0.322990	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,448,722	1,330,050	2,778,772	0.579576	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	459,288	289,810	749,098	0.384671	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	5,677,622	16,091,424	21,769,046	0.108491	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,406,373	14,809,024	26,215,397	0.249864	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,199,590	9,421,348	15,620,938	0.539236	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	16,575,267	21,742,535	38,317,802	0.375105	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	429,255	26,672,158	27,101,413	0.767242	0.000000	90.00	
91.00	09100	EMERGENCY	14,689,851	47,647,389	62,337,240	0.135308	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	500,000	3,370,949	3,870,949	1.037570	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	178,516,917	416,737,933	595,254,850			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	178,516,917	416,737,933	595,254,850			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.253821			50.00
51.00	05100	RECOVERY ROOM	0.284910			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.362688			52.00
53.00	05300	ANESTHESIOLOGY	0.015390			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293259			54.00
54.01	05401	NUCLEAR MEDICINE	0.131566			54.01
54.02	05402	ULTRASOUND	0.082157			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.191157			55.00
57.00	05700	CT SCAN	0.031643			57.00
58.00	05800	MRI	0.084079			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.129847			59.00
59.97	05901	CARDIAC REHAB	0.624329			59.97
60.00	06000	LABORATORY	0.118907			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.256488			65.00
66.00	06600	PHYSICAL THERAPY	0.322990			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.579576			67.00
68.00	06800	SPEECH PATHOLOGY	0.384671			68.00
69.00	06900	ELECTROCARDIOLOGY	0.108491			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249864			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.539236			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.375105			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.767242			90.00
91.00	09100	EMERGENCY	0.135308			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.037570			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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

Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

MCRIF32 - 16.10.172.3

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

			Title XIX		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	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	0.000000	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0.000000	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	NUCLEAR MEDICINE	0.000000			54.01
54.02	05402	ULTRASOUND	0.000000			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
59.97	05901	CARDIAC REHAB	0.000000			59.97
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,399,819	1,212,917	8,186,902	0	0
51.00	05100	RECOVERY ROOM	1,181,136	187,417	993,719	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,370,429	209,849	1,160,580	0	0
53.00	05300	ANESTHESIOLOGY	126,789	5,391	121,398	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,775,615	659,838	6,115,777	0	0
54.01	05401	NUCLEAR MEDICINE	1,247,872	91,970	1,155,902	0	0
54.02	05402	ULTRASOUND	1,499,549	48,240	1,451,309	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	2,457,464	542,212	1,915,252	0	0
57.00	05700	CT SCAN	2,277,670	199,240	2,078,430	0	0
58.00	05800	MRI	1,359,301	146,487	1,212,814	0	0
59.00	05900	CARDIAC CATHETERIZATION	2,475,370	160,921	2,314,449	0	0
59.97	05901	CARDIAC REHAB	448,952	10,069	438,883	0	0
60.00	06000	LABORATORY	14,564,528	858,801	13,705,727	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,281,657	229,358	2,052,299	0	0
66.00	06600	PHYSICAL THERAPY	2,632,838	145,361	2,487,477	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,610,510	30,747	1,579,763	0	0
68.00	06800	SPEECH PATHOLOGY	288,156	5,411	282,745	0	0
69.00	06900	ELECTROCARDIOLOGY	2,361,745	249,549	2,112,196	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,550,272	157,183	6,393,089	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,423,376	195,277	8,228,099	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	14,373,210	613,788	13,759,422	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	20,793,334	2,454,050	18,339,284	0	0
91.00	09100	EMERGENCY	8,434,757	625,829	7,808,928	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,016,379	318,358	3,698,021	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (sum of lines 50 thru 199)	116,950,728	9,358,263	107,592,465	0	0
201.00		Less Observation Beds	4,016,379	318,358	3,698,021	0	0
202.00		Total (line 200 minus line 201)	112,934,349	9,039,905	103,894,444	0	0

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,399,819	37,033,215	0.253821	50.00
51.00	05100	RECOVERY ROOM	1,181,136	4,145,641	0.284910	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,370,429	1,005,681	1.362688	52.00
53.00	05300	ANESTHESIOLOGY	126,789	8,238,508	0.015390	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,775,615	23,104,568	0.293259	54.00
54.01	05401	NUCLEAR MEDICINE	1,247,872	9,484,793	0.131566	54.01
54.02	05402	ULTRASOUND	1,499,549	18,252,242	0.082157	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,457,464	12,855,726	0.191157	55.00
57.00	05700	CT SCAN	2,277,670	71,980,539	0.031643	57.00
58.00	05800	MRI	1,359,301	16,166,966	0.084079	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,475,370	19,063,692	0.129847	59.00
59.97	05901	CARDIAC REHAB	448,952	719,095	0.624329	59.97
60.00	06000	LABORATORY	14,564,528	122,486,977	0.118907	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	2,281,657	8,895,755	0.256488	65.00
66.00	06600	PHYSICAL THERAPY	2,632,838	8,151,455	0.322990	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,610,510	2,778,772	0.579576	67.00
68.00	06800	SPEECH PATHOLOGY	288,156	749,098	0.384671	68.00
69.00	06900	ELECTROCARDIOLOGY	2,361,745	21,769,046	0.108491	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,550,272	26,215,397	0.249864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,423,376	15,620,938	0.539236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,373,210	38,317,802	0.375105	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,793,334	27,101,413	0.767242	90.00
91.00	09100	EMERGENCY	8,434,757	62,337,240	0.135308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,016,379	3,870,949	1.037570	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	93.99
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	116,950,728	560,345,508		200.00
201.00		Less Observation Beds	4,016,379	0		201.00
202.00		Total (line 200 minus line 201)	112,934,349	560,345,508		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

			Title V		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	20,412,160		20,412,160	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,908,790		6,908,790	0	0	31.00
43.00	04300	NURSERY	1,296,387		1,296,387	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,399,819		9,399,819	0	0	50.00
51.00	05100	RECOVERY ROOM	1,181,136		1,181,136	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,370,429		1,370,429	0	0	52.00
53.00	05300	ANESTHESIOLOGY	126,789		126,789	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,775,615		6,775,615	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	1,247,872		1,247,872	0	0	54.01
54.02	05402	ULTRASOUND	1,499,549		1,499,549	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	2,457,464		2,457,464	0	0	55.00
57.00	05700	CT SCAN	2,277,670		2,277,670	0	0	57.00
58.00	05800	MRI	1,359,301		1,359,301	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,475,370		2,475,370	0	0	59.00
59.97	05901	CARDIAC REHAB	448,952		448,952	0	0	59.97
60.00	06000	LABORATORY	14,564,528		14,564,528	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,281,657	0	2,281,657	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,632,838	0	2,632,838	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,610,510	0	1,610,510	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	288,156	0	288,156	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,361,745		2,361,745	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,550,272		6,550,272	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,423,376		8,423,376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,373,210		14,373,210	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	20,793,334		20,793,334	0	0	90.00
91.00	09100	EMERGENCY	8,434,757		8,434,757	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	141,551,686	0	141,551,686	0	0	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	141,551,686	0	141,551,686	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

			Title V			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
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
43.00	04300	NURSERY	0		0			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
54.01	05401	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000	54.01	
54.02	05402	ULTRASOUND	0	0	0	0.000000	0.000000	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
59.97	05901	CARDIAC REHAB	0	0	0	0.000000	0.000000	59.97	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			PPS Inpatient Ratio	Title V	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	NUCLEAR MEDICINE	0.000000			54.01
54.02	05402	ULTRASOUND	0.000000			54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
59.97	05901	CARDIAC REHAB	0.000000			59.97
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

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)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,617,977	0	1,617,977	13,595	119.01	30.00
31.00	INTENSIVE CARE UNIT		539,958		539,958	2,619	206.17	31.00
43.00	NURSERY		58,865		58,865	837	70.33	43.00
200.00	Total (lines 30 through 199)		2,216,800		2,216,800	17,051		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		6,497	773,208				
31.00	INTENSIVE CARE UNIT		1,159	238,951				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		7,656	1,012,159				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,212,917	37,033,215	0.032752	4,835,247	158,364	50.00
51.00	05100	RECOVERY ROOM	187,417	4,145,641	0.045208	714,704	32,310	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,849	1,005,681	0.208664	4,254	888	52.00
53.00	05300	ANESTHESIOLOGY	5,391	8,238,508	0.000654	1,205,417	788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,838	23,104,568	0.028559	3,508,552	100,201	54.00
54.01	05401	NUCLEAR MEDICINE	91,970	9,484,793	0.009697	585,801	5,681	54.01
54.02	05402	ULTRASOUND	48,240	18,252,242	0.002643	1,259,295	3,328	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	542,212	12,855,726	0.042177	0	0	55.00
57.00	05700	CT SCAN	199,240	71,980,539	0.002768	7,308,289	20,229	57.00
58.00	05800	MRI	146,487	16,166,966	0.009061	1,368,143	12,397	58.00
59.00	05900	CARDIAC CATHETERIZATION	160,921	19,063,692	0.008441	3,676,840	31,036	59.00
59.97	05901	CARDIAC REHAB	10,069	719,095	0.014002	1,089	15	59.97
60.00	06000	LABORATORY	858,801	122,486,977	0.007011	17,216,531	120,705	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	229,358	8,895,755	0.025783	4,388,279	113,143	65.00
66.00	06600	PHYSICAL THERAPY	145,361	8,151,455	0.017833	1,798,962	32,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,747	2,778,772	0.011065	1,002,318	11,091	67.00
68.00	06800	SPEECH PATHOLOGY	5,411	749,098	0.007223	306,105	2,211	68.00
69.00	06900	ELECTROCARDIOLOGY	249,549	21,769,046	0.011463	3,290,266	37,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,183	26,215,397	0.005996	6,272,761	37,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,277	15,620,938	0.012501	4,241,053	53,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,788	38,317,802	0.016018	8,848,403	141,734	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,454,050	27,101,413	0.090551	11,767	1,066	90.00
91.00	09100	EMERGENCY	625,829	62,337,240	0.010039	7,942,754	79,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,358	3,870,949	0.082243	162,679	13,379	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	9,358,263	560,345,508		79,949,509	1,008,728	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 2:21 pm		
						Title XVIII		Hospital		PPS		
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
						1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0		0		0		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0		0		0		31.00	
43.00	04300	NURSERY		0	0		0		0		43.00	
200.00		Total (lines 30 through 199)		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		13,595		0.00	6,497	30.00	
31.00	03100	INTENSIVE CARE UNIT			0		2,619		0.00	1,159	31.00	
43.00	04300	NURSERY			0		837		0.00	0	43.00	
200.00		Total (lines 30 through 199)			0		17,051			7,656	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	
43.00	04300	NURSERY		0							43.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0 54.01
54.02	05402	ULTRASOUND	0	0	0	0	0 54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0 59.97
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0101

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	37,033,215	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,145,641	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,005,681	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,238,508	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,104,568	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	9,484,793	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	18,252,242	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	12,855,726	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	71,980,539	0.000000	57.00
58.00	05800	MRI	0	0	0	16,166,966	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	19,063,692	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	719,095	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	122,486,977	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,895,755	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,151,455	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,778,772	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	749,098	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21,769,046	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,215,397	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,620,938	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,317,802	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	27,101,413	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	62,337,240	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,870,949	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	560,345,508		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,835,247	0	8,527,272	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	714,704	0	762,987	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,254	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,205,417	0	1,634,316	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,508,552	0	3,771,057	0	54.00
54.01	05401	NUCLEAR MEDICINE	0.000000	585,801	0	3,755,437	0	54.01
54.02	05402	ULTRASOUND	0.000000	1,259,295	0	3,269,248	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	6,673	0	55.00
57.00	05700	CT SCAN	0.000000	7,308,289	0	16,625,054	0	57.00
58.00	05800	MRI	0.000000	1,368,143	0	4,457,917	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,676,840	0	5,746,438	0	59.00
59.97	05901	CARDIAC REHAB	0.000000	1,089	0	337,127	0	59.97
60.00	06000	LABORATORY	0.000000	17,216,531	0	10,952,019	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	4,388,279	0	682,568	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,798,962	0	155,533	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,002,318	0	50,995	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	306,105	0	13,172	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,290,266	0	5,504,100	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,272,761	0	4,372,036	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,241,053	0	3,247,018	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,848,403	0	9,654,965	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	11,767	0	2,043,472	0	90.00
91.00	09100	EMERGENCY	0.000000	7,942,754	0	10,477,518	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	162,679	0	2,001,116	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		79,949,509	0	98,048,038	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/28/2021 2:21 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.253821	8,527,272	0	38	2,164,401	50.00
51.00	05100	RECOVERY ROOM		0.284910	762,987	0	0	217,383	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		1.362688	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.015390	1,634,316	0	0	25,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.293259	3,771,057	0	0	1,105,896	54.00
54.01	05401	NUCLEAR MEDICINE		0.131566	3,755,437	0	6	494,088	54.01
54.02	05402	ULTRASOUND		0.082157	3,269,248	0	0	268,592	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC		0.191157	6,673	0	0	1,276	55.00
57.00	05700	CT SCAN		0.031643	16,625,054	0	0	526,067	57.00
58.00	05800	MRI		0.084079	4,457,917	0	295	374,817	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.129847	5,746,438	0	0	746,158	59.00
59.97	05901	CARDIAC REHAB		0.624329	337,127	0	0	210,478	59.97
60.00	06000	LABORATORY		0.118907	10,952,019	0	0	1,302,272	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.256488	682,568	0	0	175,071	65.00
66.00	06600	PHYSICAL THERAPY		0.322990	155,533	0	0	50,236	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.579576	50,995	0	0	29,555	67.00
68.00	06800	SPEECH PATHOLOGY		0.384671	13,172	0	0	5,067	68.00
69.00	06900	ELECTROCARDIOLOGY		0.108491	5,504,100	0	14	597,145	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.249864	4,372,036	0	8	1,092,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.539236	3,247,018	0	0	1,750,909	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.375105	9,654,965	0	66,205	3,621,626	73.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.767242	2,043,472	0	744	1,567,838	90.00
91.00	09100	EMERGENCY		0.135308	10,477,518	0	0	1,417,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		1.037570	2,001,116	0	0	2,076,298	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)			98,048,038	0	67,310	19,820,431	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			98,048,038	0	67,310	19,820,431	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/28/2021 2:21 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	10					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	NUCLEAR MEDICINE	0	1					54.01
54.02	05402	ULTRASOUND	0	0					54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	25					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
59.97	05901	CARDIAC REHAB	0	0					59.97
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	2					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,834					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	571					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0					93.99
200.00		Subtotal (see instructions)	0	25,445					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	25,445					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,617,977	0	1,617,977	13,595	119.01	30.00
31.00	INTENSIVE CARE UNIT	539,958		539,958	2,619	206.17	31.00
43.00	NURSERY	58,865		58,865	837	70.33	43.00
200.00	Total (lines 30 through 199)	2,216,800		2,216,800	17,051		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	329	39,154				30.00
31.00	INTENSIVE CARE UNIT	16	3,299				31.00
43.00	NURSERY	99	6,963				43.00
200.00	Total (lines 30 through 199)	444	49,416				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,212,917	0	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	187,417	0	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,849	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	5,391	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,838	0	0.000000	0	54.00
54.01	05401	NUCLEAR MEDICINE	91,970	0	0.000000	0	54.01
54.02	05402	ULTRASOUND	48,240	0	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	542,212	0	0.000000	0	55.00
57.00	05700	CT SCAN	199,240	0	0.000000	0	57.00
58.00	05800	MRI	146,487	0	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	160,921	0	0.000000	0	59.00
59.97	05901	CARDIAC REHAB	10,069	0	0.000000	0	59.97
60.00	06000	LABORATORY	858,801	0	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	229,358	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	145,361	0	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,747	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,411	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	249,549	0	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,183	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,277	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,788	0	0.000000	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,454,050	0	0.000000	0	90.00
91.00	09100	EMERGENCY	625,829	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,358	0	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
200.00		Total (lines 50 through 199)	9,358,263	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 2:21 pm		
						Title XIX		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		30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0		0		0		31.00	
43.00	04300	NURSERY		0	0		0		0		43.00	
200.00		Total (lines 30 through 199)		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		13,595		0.00	329	30.00	
31.00	03100	INTENSIVE CARE UNIT			0		2,619		0.00	16	31.00	
43.00	04300	NURSERY			0		837		0.00	99	43.00	
200.00		Total (lines 30 through 199)			0		17,051			444	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	
43.00	04300	NURSERY		0							43.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Title XIX		Hospital		PPS
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0 54.01
54.02	05402	ULTRASOUND	0	0	0	0	0 54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0 59.97
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0101

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Title XIX			Hospital	PPS	
			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)	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0.000000	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0.000000	59.97
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

				Title XIX		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0.000000	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0.000000	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0.000000	0	0	0	0	59.97
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

			Title V		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,617,977	0	1,617,977	13,595	119.01	30.00
31.00	INTENSIVE CARE UNIT	539,958		539,958	2,619	206.17	31.00
43.00	NURSERY	58,865		58,865	837	70.33	43.00
200.00	Total (lines 30 through 199)	2,216,800		2,216,800	17,051		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	0	0				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Title V		Hospital		Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,212,917	0	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	187,417	0	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,849	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	5,391	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	659,838	0	0.000000	0	54.00
54.01	05401	NUCLEAR MEDICINE	91,970	0	0.000000	0	54.01
54.02	05402	ULTRASOUND	48,240	0	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	542,212	0	0.000000	0	55.00
57.00	05700	CT SCAN	199,240	0	0.000000	0	57.00
58.00	05800	MRI	146,487	0	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	160,921	0	0.000000	0	59.00
59.97	05901	CARDIAC REHAB	10,069	0	0.000000	0	59.97
60.00	06000	LABORATORY	858,801	0	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	229,358	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	145,361	0	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,747	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,411	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	249,549	0	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,183	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,277	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,788	0	0.000000	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,454,050	0	0.000000	0	90.00
91.00	09100	EMERGENCY	625,829	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
200.00		Total (lines 50 through 199)	9,039,905	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2021 2:21 pm		
						Title V		Hospital		Cost		
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
						1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	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	13,595	0.00	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT			0	2,619	0.00	0	0	31.00		
43.00	04300	NURSERY			0	837	0.00	0	0	43.00		
200.00		Total (lines 30 through 199)			0	17,051		0	0	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		
43.00	04300	NURSERY		0						43.00		
200.00		Total (lines 30 through 199)		0						200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0101		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2021 2:21 pm	
			Title V		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0	54.01
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
59.97	05901	CARDIAC REHAB	0	0	0	0	0	59.97
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0101

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description			Title V		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000
54.01	05401	NUCLEAR MEDICINE	0	0	0	0	0.000000
54.02	05402	ULTRASOUND	0	0	0	0	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000
57.00	05700	CT SCAN	0	0	0	0	0.000000
58.00	05800	MRI	0	0	0	0	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000
59.97	05901	CARDIAC REHAB	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	0	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	0	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	0	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2021 2:21 pm

				Title V		Hospital	Cost		
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00	
54.01	05401	NUCLEAR MEDICINE	0.000000	0	0	0	0	54.01	
54.02	05402	ULTRASOUND	0.000000	0	0	0	0	54.02	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
59.97	05901	CARDIAC REHAB	0.000000	0	0	0	0	59.97	
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00		Total (lines 50 through 199)		0	0	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 2:21 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,595	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,595	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)	10,920	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	6,497	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,412,160	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,412,160	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	20,412,160	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,501.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,754,921	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	9,754,921	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
7/28/2021 2:21 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,908,790	2,619	2,637.95	1,159	3,057,384
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					16,724,370
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,536,675
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,012,159
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,008,728
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,020,887
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,515,788
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,675
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,501.45
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,016,379

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
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		Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,617,977	20,412,160	0.079265	4,016,379	318,358
91.00	Nursing School cost	0	20,412,160	0.000000	4,016,379	0
92.00	Allied health cost	0	20,412,160	0.000000	4,016,379	0
93.00	All other Medical Education	0	20,412,160	0.000000	4,016,379	0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
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Title XIX		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)	13,595	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,595	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)	10,920	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)	329	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)	837	15.00
16.00	Nursery days (title V or XIX only)	99	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,412,160	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,412,160	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	20,412,160	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,501.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	493,977	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)	493,977	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

Worksheet D-1

Date/Time Prepared:
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		Title XIX		Hospital		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	1,296,387	837	1,548.85	99	153,336	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	6,908,790	2,619	2,637.95	16	42,207	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						689,520	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)						49,416	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						49,416	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						640,104	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)						2,675	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,501.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,016,379	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0101

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

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Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,617,977	20,412,160	0.079265	4,016,379	318,358
91.00	Nursing School cost	0	20,412,160	0.000000	4,016,379	0
92.00	Allied health cost	0	20,412,160	0.000000	4,016,379	0
93.00	All other Medical Education	0	20,412,160	0.000000	4,016,379	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2021 2:21 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		11,618,925	30.00
31.00	03100	INTENSIVE CARE UNIT		5,119,346	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.253821	4,835,247	50.00
51.00	05100	RECOVERY ROOM	0.284910	714,704	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.362688	4,254	52.00
53.00	05300	ANESTHESIOLOGY	0.015390	1,205,417	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293259	3,508,552	54.00
54.01	05401	NUCLEAR MEDICINE	0.131566	585,801	54.01
54.02	05402	ULTRASOUND	0.082157	1,259,295	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.191157	0	55.00
57.00	05700	CT SCAN	0.031643	7,308,289	57.00
58.00	05800	MRI	0.084079	1,368,143	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.129847	3,676,840	59.00
59.97	05901	CARDIAC REHAB	0.624329	1,089	59.97
60.00	06000	LABORATORY	0.118907	17,216,531	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.256488	4,388,279	65.00
66.00	06600	PHYSICAL THERAPY	0.322990	1,798,962	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.579576	1,002,318	67.00
68.00	06800	SPEECH PATHOLOGY	0.384671	306,105	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108491	3,290,266	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.249864	6,272,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.539236	4,241,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.375105	8,848,403	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.767242	11,767	90.00
91.00	09100	EMERGENCY	0.135308	7,942,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.037570	162,679	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		79,949,509	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)		79,949,509	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 2:21 pm
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		12,268,538	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,089,513	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)		903,693	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		301,231	2.04
3.00	Managed Care Simulated Payments		2,712,930	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		81.69	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)		2.30	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.78	31.00
32.00	Sum of lines 30 and 31		16.08	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.21	33.00
34.00	Disproportionate share adjustment (see instructions)		131,273	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2021 2:21 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	0	35.00
35.01	Factor 3 (see instructions)		0.000166745	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,392,421	1,169,843	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,042,414	294,865	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,337,279		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		19,031,527		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)			19,031,527	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,400,815	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			391,095	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)			20,823,437	59.00
60.00	Primary payer payments			945	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			20,822,492	61.00
62.00	Deductibles billed to program beneficiaries			1,727,000	62.00
63.00	Coinurance billed to program beneficiaries			5,632	63.00
64.00	Allowable bad debts (see instructions)			354,394	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			230,356	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			229,063	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			19,320,216	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			143,271	70.93
70.94	HRR adjustment amount (see instructions)			-101,121	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
7/28/2021 2:21 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		19,362,366		71.00
71.01	Sequestration adjustment (see instructions)		127,792		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		18,815,436		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)		419,138		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		350,789		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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 2:21 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12,268,538	0	12,268,538		12,268,538
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,089,513	0		4,089,513	4,089,513
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	903,693	0	903,693		903,693
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	301,231	0		301,231	301,231
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	2,712,930	0	2,034,697	678,233	2,712,930
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0321	0.0321	0.0321	0.0321	
11.00	Disproportionate share adjustment (see instructions)	34.00	131,273	0	98,455	32,818	131,273
11.01	Uncompensated care payments	36.00	1,337,279	0	1,042,414	294,865	1,337,279
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	19,031,527	0	14,313,100	4,718,427	19,031,527
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,031,527	0	14,313,100	4,718,427	19,031,527
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,400,815	0	1,050,611	350,204	1,400,815

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2021 2:21 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	391,095	0	293,321	97,774	391,095	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	15,657,032	5,166,405	20,823,437	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,269,723	0	952,292	317,431	1,269,723	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	131,092	0	98,319	32,773	131,092	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,400,815	0	1,050,611	350,204	1,400,815	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 2:21 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12,268,538	12,268,538		12,268,538	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,089,513		4,089,513	4,089,513	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	903,693	903,693		903,693	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	301,231		301,231	301,231	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,712,930	2,034,698	678,232	2,712,930	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	0.0321	0.0321	0.0321		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	131,273	98,455	32,818	131,273	11.00
11.01	Uncompensated care payments	36.00	1,337,279	1,042,414	294,865	1,337,279	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	19,031,527	14,313,100	4,718,427	19,031,527	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	19,031,527	14,313,100	4,718,427	19,031,527	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,400,815	1,050,611	350,204	1,400,815	16.00
17.00	Special add-on payments for new technologies	54.00	391,095	293,321	97,774	391,095	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			15,657,032	5,166,405	20,823,437	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2021 2:21 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,269,723	952,292	317,431	1,269,723	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	131,092	98,319	32,773	131,092	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	1,400,815	1,050,611	350,204	1,400,815	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	143,271	107,453	35,818	143,271	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	-101,121	-75,841	-25,280	-101,121	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2021 2:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		25,445	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,820,431	2.00
3.00	OPPS payments		12,297,905	3.00
4.00	Outlier payment (see instructions)		144,030	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)		25,445	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		67,310	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)		67,310	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)		67,310	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		41,865	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)		25,445	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)		12,441,935	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,343,679	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)		10,123,701	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)		10,123,701	30.00
31.00	Primary payer payments		667	31.00
32.00	Subtotal (line 30 minus line 31)		10,123,034	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)		442,118	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		287,377	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		285,562	36.00
37.00	Subtotal (see instructions)		10,410,411	37.00
38.00	MSP-LCC reconciliation amount from PS&R		967	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)		10,409,444	40.00
40.01	Sequestration adjustment (see instructions)		68,702	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		10,047,020	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)		293,722	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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/28/2021 2:21 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		18,848,878		10,047,020	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	11/25/2020	33,442		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)		-33,442		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		18,815,436		10,047,020	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		419,138		293,722	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		19,234,574		10,340,742	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: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/28/2021 2:21 pm	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

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

Provider CCN: 14-0101

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

Worksheet G

Date/Time Prepared:
7/28/2021 2:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	43,480,791	0	0	0	1.00
2.00	Temporary investments	29,592	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	64,447,776	0	0	0	4.00
5.00	Other receivable	-117,409	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-45,265,376	0	0	0	6.00
7.00	Inventory	3,551,045	0	0	0	7.00
8.00	Prepaid expenses	5,270,005	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)	71,396,424	0	0	0	11.00
FIXED ASSETS						
12.00	Land	10,882,648	0	0	0	12.00
13.00	Land improvements	7,567,111	0	0	0	13.00
14.00	Accumulated depreciation	-5,767,673	0	0	0	14.00
15.00	Buildings	86,123,501	0	0	0	15.00
16.00	Accumulated depreciation	-50,109,133	0	0	0	16.00
17.00	Leasehold improvements	2,342,649	0	0	0	17.00
18.00	Accumulated depreciation	-95,431	0	0	0	18.00
19.00	Fixed equipment	28,082,871	0	0	0	19.00
20.00	Accumulated depreciation	-21,100,968	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	83,076,229	0	0	0	23.00
24.00	Accumulated depreciation	-65,606,507	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	41,827,810	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	117,223,107	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	115,182,808	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	18,769,813	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	133,952,621	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	322,572,152	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,753,210	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,397,715	0	0	0	38.00
39.00	Payroll taxes payable	174,579	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,839,592	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	21,753,287	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	40,918,383	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	89,715,109	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	30,019,692	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	119,734,801	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	160,653,184	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	161,918,968				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)	161,918,968	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	322,572,152	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0101

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

Worksheet G-1

Date/Time Prepared:
7/28/2021 2:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		155,315,529		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,485,439				2.00
3.00	Total (sum of line 1 and line 2)		161,800,968		0		3.00
4.00	TRANSFER FROM AFFILIATE	118,000		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)		118,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		161,918,968		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)		161,918,968		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	TRANSFER FROM AFFILIATE		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: 14-0101

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2021 2:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,282,311		25,282,311	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)	25,282,311		25,282,311	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	9,627,031		9,627,031	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	9,627,031		9,627,031	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,909,342		34,909,342	17.00
18.00	Ancillary services	127,988,469	339,047,437	467,035,906	18.00
19.00	Outpatient services	14,719,106	78,590,495	93,309,601	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	PHYSICIAN PRIVATE OFFICES	922	12,042,315	12,043,237	27.00
27.01	PROFESSIONAL CHARGES	385,069	5,376,872	5,761,941	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	178,002,908	435,057,119	613,060,027	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		177,206,184		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	OTHER EXPENSE	427,034			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)		427,034		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		176,779,150		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0101

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

Worksheet G-3

Date/Time Prepared:
7/28/2021 2:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	613,060,027	1.00
2.00	Less contractual allowances and discounts on patients' accounts	448,489,906	2.00
3.00	Net patient revenues (line 1 minus line 2)	164,570,121	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	176,779,150	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,209,029	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,779,215	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 OPERATING REVENUE	1,981,233	24.00
24.01	NONOPERATING INCOME	700	24.01
24.02	PROVIDER RELIEF FUNDING	10,175,507	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	19,936,655	25.00
26.00	Total (line 5 plus line 25)	7,727,626	26.00
27.00	NET STLMTS FOR DERIVATIVE INSTRUMENT	427,034	27.00
27.01	CHANGE IN FAIR VALUE OF INT RATE SWA	815,153	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,242,187	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,485,439	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0101	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/28/2021 2:21 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,269,723	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		131,092	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)		38.29	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)		1,400,815	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