

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: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/24/2020 4:58 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/24/2020	Time: 4:58 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 ELMHURST MEMORIAL HOSPITAL (14-0200) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DENISE CHAMBERLAIN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	293,927	412,031	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	293,927	412,031	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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 155 E BRUSH HILL ROAD			PO Box:						1.00		
2.00	City: ELMHURST			State: IL		Zip Code: 60126		County: DUPAGE		2.00		
		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		ELMHURST MEMORIAL HOSPITAL		140200	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00	3.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	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.			3,147	0	0	0	5,798	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			Y	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)					23.00	1	60.01

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To 06/30/2020Worksheet 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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
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	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 4:58 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:	0	0	6,378,561118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H131	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/24/2020 4:58 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: EDWARD ELMHURST HEALTH		Contractor's Name: NGS		Contractor's Number: 00131				141.00	
142.00	Street: 801 SOUTH WASHINGTON STREET		PO Box:						142.00	
143.00	City: NAPERVILLE		State: IL		Zip Code: 60540				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						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		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/24/2020 4:58 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.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			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.	Y			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/14/2020	Y	10/14/2020
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)	N		N	
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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/24/2020 4:58 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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
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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.	CONSULTANT		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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 4:58 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	219	80,154	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)		219	80,154	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	39	14,274	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)		258	94,428	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)		258			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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 4:58 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)	25,649	1,990	56,166			1.00
2.00	HMO and other (see instructions)	10,322	5,798				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)	25,649	1,990	56,166			7.00
8.00	INTENSIVE CARE UNIT	1,951	366	11,781			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		791	7,315			13.00
14.00	Total (see instructions)	27,600	3,147	75,262	0.00	2,184.24	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)			597			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	2,184.24	27.00
28.00	Observation Bed Days		0	5,725			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	613	1,917			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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/24/2020 4:58 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	5,916	394	17,370	1.00
2.00 HMO and other (see instructions)			1,996	1,379		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	5,916	394	17,370	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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/24/2020 4:58 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	143,959,201	0	143,959,201	4,398,062.00	32.73
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		299,626	0	299,626	2,559.00	117.09
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		579,882	0	579,882	4,414.00	131.37
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,961,547	153,394	3,114,941	119,141.00	26.14
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,282,940	0	1,282,940	11,763.00	109.07
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		5,773,836	0	5,773,836	46,191.00	125.00
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		29,184,420	0	29,184,420	737,605.00	39.57
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)		35,116,103	0	35,116,103		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		873,366	0	873,366		
20.00	Non-physician anesthetist Part A		3	0	3		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		25,155	0	25,155		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		43,442	0	43,442		
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)		5,848,756	0	5,848,756		
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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/24/2020 4:58 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	1,090,343	0	1,090,343	19,687.00	55.38	26.00
27.00	Administrative & General	5.00	11,178,424	0	11,178,424	219,938.00	50.83	27.00
28.00	Administrative & General under contract (see inst.)		665,213	0	665,213	4,435.00	149.99	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,173,520	-60,876	2,112,644	57,831.00	36.53	30.00
31.00	Laundry & Linen Service	8.00	1,032,959	0	1,032,959	63,545.00	16.26	31.00
32.00	Housekeeping	9.00	4,200,959	-92,518	4,108,441	243,475.00	16.87	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,764,587	-1,283,896	1,480,691	79,103.00	18.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,283,896	1,283,896	68,590.00	18.72	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,397,479	0	2,397,479	37,909.00	63.24	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	3,592,470	0	3,592,470	79,405.00	45.24	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/24/2020 4:58 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)	144,044,532	0	144,044,532	4,398,083.00	32.75	1.00
2.00	Excluded area salaries (see instructions)	2,961,547	153,394	3,114,941	119,141.00	26.14	2.00
3.00	Subtotal salaries (line 1 minus line 2)	141,082,985	-153,394	140,929,591	4,278,942.00	32.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	36,241,196	0	36,241,196	795,559.00	45.55	4.00
5.00	Subtotal wage-related costs (see inst.)	40,990,014	0	40,990,014	0.00	29.09	5.00
6.00	Total (sum of lines 3 thru 5)	218,314,195	-153,394	218,160,801	5,074,501.00	42.99	6.00
7.00	Total overhead cost (see instructions)	29,095,954	-153,394	28,942,560	873,918.00	33.12	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 11/24/2020 4:58 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		5,248,231	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)		2,000,000	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)		15,024,930	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		680,566	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		131,362	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		1,039,465	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		800,400	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		10,522,917	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		41,581	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		568,614	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		36,058,066	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
11/24/2020 4:58 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	1,282,940	36,058,066	1.00
2.00	Hospital	1,282,940	35,116,103	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	0	0	17.00
18.00	Other	0	941,963	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-5

Date/Time Prepared:
11/24/2020 4:58 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	0	0					5.00
6.00	Number of stations	0	0	0	0			6.00
7.00	Treatment capacity per day per station	0	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00
							Y/N	
							1.00	
ESRD PPS								
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02
						Prior to 1/1	After 12/31	
						1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	4
TRANSPLANT INFORMATION								
11.00	Number of patients on transplant list						0	11.00
12.00	Number of patients transplanted during the cost reporting period						0	12.00
EPOETIN								
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.							13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program							14.00
15.00	Number of EPO units furnished relating to the renal dialysis department							15.00
16.00	Number of EPO units furnished relating to the home dialysis department							16.00
ARANESP								
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.							17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program							18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department							19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department							20.00
						MCP	INITIAL METHOD	
						1.00	2.00	
PHYSICIAN PAYMENT METHOD								
21.00	Enter "X" if method(s) is applicable							21.00
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.		
		1.00	2.00	3.00	4.00	5.00		
ESAs								
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						0	0

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-5

Date/Time Prepared:
11/24/2020 4:58 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/24/2020 4:58 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)		0.164925	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		21,948,478	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		250,233,654	6.00	
7.00	Medicaid cost (line 1 times line 6)		41,269,785	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)		19,321,307	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)		19,321,307	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	25,194,186	12,758,763	37,952,949	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,155,151	12,758,763	16,913,914	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,155,151	12,758,763	16,913,914	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		32,397,263	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		887,695	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,365,684	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		31,031,579	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		5,595,872	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		22,509,786	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		41,831,093	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0200

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

Worksheet A

Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		16,495,018	16,495,018	-315,246	16,179,772	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,664,232	10,664,232	0	10,664,232	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,090,343	18,370,405	19,460,748	0	19,460,748	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,178,424	120,974,159	132,152,583	1,341,142	133,493,725	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,173,520	13,913,910	16,087,430	-200,094	15,887,336	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,032,959	801,380	1,834,339	0	1,834,339	8.00
9.00	00900	HOUSEKEEPING	4,200,959	1,281,038	5,481,997	-97,743	5,384,254	9.00
10.00	01000	DIETARY	2,764,587	1,729,277	4,493,864	-2,086,986	2,406,878	10.00
11.00	01100	CAFETERIA	0	0	0	2,086,986	2,086,986	11.00
13.00	01300	NURSING ADMINISTRATION	2,397,479	124,247	2,521,726	0	2,521,726	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,592,470	42,926,475	46,518,945	-41,964,460	4,554,485	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
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	439,407	11,072	450,479	0	450,479	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,879,502	3,001,925	27,881,427	-3,147,409	24,734,018	30.00
31.00	03100	INTENSIVE CARE UNIT	7,745,289	1,710,182	9,455,471	-1,042,482	8,412,989	31.00
43.00	04300	NURSERY	1,450,034	210,153	1,660,187	1,458,948	3,119,135	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,345,117	42,557,601	54,902,718	-38,105,597	16,797,121	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,096,515	828,819	4,925,334	-650,263	4,275,071	52.00
53.00	05300	ANESTHESIOLOGY	216,161	651,875	868,036	-418,252	449,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,461,334	2,955,035	7,416,369	-3,179,693	4,236,676	54.00
54.01	03630	ULTRASOUND	1,370,940	256,084	1,627,024	-120,409	1,506,615	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,468,912	394,113	2,863,025	-142,010	2,721,015	55.00
55.01	05501	CYBERKNIFE	464,934	1,516,621	1,981,555	38,145	2,019,700	55.01
56.00	05600	RADIOISOTOPE	508,066	1,811,235	2,319,301	15,860	2,335,161	56.00
57.00	05700	CT SCAN	1,091,625	926,194	2,017,819	-397,010	1,620,809	57.00
58.00	05800	MRI	830,362	212,698	1,043,060	-28,000	1,015,060	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,309,754	8,697,116	11,006,870	-8,022,430	2,984,440	59.00
60.00	06000	LABORATORY	6,571,738	11,521,316	18,093,054	-6,537,031	11,556,023	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,084,792	830,862	2,915,654	-340,438	2,575,216	65.00
65.01	03610	SLEEP LAB	403,990	119,228	523,218	-50,991	472,227	65.01
66.00	06600	PHYSICAL THERAPY	3,204,326	44,332	3,248,658	-12,070	3,236,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	843,805	3,320	847,125	-615	846,510	67.00
68.00	06800	SPEECH PATHOLOGY	335,915	1,684	337,599	-233	337,366	68.00
69.00	06900	ELECTROCARDIOLOGY	890,558	1,912,945	2,803,503	-193,800	2,609,703	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	340,860	4,880	345,740	-3,929	341,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,483,393	32,483,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,523,427	32,523,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,115,543	38,115,543	73.00
74.00	07400	RENAL DIALYSIS	0	872,807	872,807	-20	872,787	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	474,856	13,856	488,712	-5,122	483,590	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	23,740,848	14,027,989	37,768,837	-1,217,493	36,551,344	90.00
90.01	09001	OUTPATIENT CLINICS	2,565,791	1,253,860	3,819,651	-365,520	3,454,131	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	772,707	772,707	90.02
91.00	09100	EMERGENCY	6,870,889	2,033,038	8,903,927	-803,888	8,100,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,437,061	325,660,981	467,098,042	-613,083	466,484,959	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	336,217	610,775	946,992	0	946,992	190.00
190.01	19001	FOUNDATION	507,634	10,000	517,634	0	517,634	190.01
191.00	19100	RESEARCH	144,797	2,919	147,716	0	147,716	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	868,220	868,220	613,083	1,481,303	192.00
192.01	19201	SCHOOL NURSES	1,533,492	835	1,534,327	0	1,534,327	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	143,959,201	327,153,730	471,112,931	0	471,112,931	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0200

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

Worksheet A

Date/Time Prepared:
11/24/2020 4:58 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	0	16,179,772	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,778,988	13,443,220	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,892,995	24,353,743	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,834,705	119,659,020	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-2,060,899	13,826,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,147,517	686,822	8.00
9.00	00900	HOUSEKEEPING	-48,310	5,335,944	9.00
10.00	01000	DIETARY	0	2,406,878	10.00
11.00	01100	CAFETERIA	-1,359,322	727,664	11.00
13.00	01300	NURSING ADMINISTRATION	-148,244	2,373,482	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	302,708	4,857,193	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,587,748	2,587,748	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	-4,800	445,679	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-31,428	24,702,590	30.00
31.00	03100	INTENSIVE CARE UNIT	-4,345	8,408,644	31.00
43.00	04300	NURSERY	0	3,119,135	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	16,797,121	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-248,220	4,026,851	52.00
53.00	05300	ANESTHESIOLOGY	0	449,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-101,017	4,135,659	54.00
54.01	03630	ULTRASOUND	-9,400	1,497,215	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,721,015	55.00
55.01	05501	CYBERKNIFE	-433,057	1,586,643	55.01
56.00	05600	RADIOISOTOPE	0	2,335,161	56.00
57.00	05700	CT SCAN	-90,365	1,530,444	57.00
58.00	05800	MRI	0	1,015,060	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,984,440	59.00
60.00	06000	LABORATORY	-6,051,046	5,504,977	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,575,216	65.00
65.01	03610	SLEEP LAB	0	472,227	65.01
66.00	06600	PHYSICAL THERAPY	-20,671	3,215,917	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	846,510	67.00
68.00	06800	SPEECH PATHOLOGY	0	337,366	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,674,067	935,636	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	341,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,483,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,523,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	38,115,543	73.00
74.00	07400	RENAL DIALYSIS	0	872,787	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	483,590	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	-6,468,472	30,082,872	90.00
90.01	09001	OUTPATIENT CLINICS	-1,188,520	2,265,611	90.01
90.02	09003	OUTPATIENT SERVICES	0	772,707	90.02
91.00	09100	EMERGENCY	0	8,100,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-24,361,966	442,122,993	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	946,992	190.00
190.01	19001	FOUNDATION	0	517,634	190.01
191.00	19100	RESEARCH	0	147,716	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,481,303	192.00
192.01	19201	SCHOOL NURSES	0	1,534,327	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-24,361,966	446,750,965	200.00

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 4:58 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	1,283,896	803,090		1.00
	TOTALS		1,283,896	803,090		
	C - DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	38,115,543		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,848,917		2.00
	TOTALS		0	41,964,460		
	D - RADIOLOGY SUPPORT					
1.00	ULTRASOUND	54.01	91,688	1,566		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	165,120	2,410		2.00
3.00	CYBERKNIFE	55.01	31,095	9,273		3.00
4.00	RADIOISOTOPE	56.00	33,979	11,074		4.00
5.00	CT SCAN	57.00	73,008	5,663		5.00
6.00	MRI	58.00	55,535	1,300		6.00
	TOTALS		450,425	31,286		
	E - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	32,483,393		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	TOTALS		0	32,483,393		
	G - NURSERY					
1.00	NURSERY	43.00	1,091,658	115,505		1.00
	TOTALS		1,091,658	115,505		
	I - REHAB ADMIN					
1.00	OCCUPATIONAL THERAPY	67.00	0	908		1.00
2.00	SPEECH PATHOLOGY	68.00	0	460		2.00
	TOTALS		0	1,368		
	J - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	32,523,427		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	40		2.00
3.00	RADIOISOTOPE	56.00	0	5,920		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	32,529,387		
	K - LOMBARD POB COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	125,077	245,906		1.00
2.00		0.00	0	0		2.00
	TOTALS		125,077	245,906		

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 4:58 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - POB BUILDING COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	28,317	213,783	1.00	
2.00		0.00	0	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	318,604	3.00	
	TOTALS		28,317	532,387		
	M - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	998,947	1.00	
2.00	NURSERY	43.00	0	360,154	2.00	
3.00	OPERATING ROOM	50.00	0	302,824	3.00	
4.00	EMERGENCY	91.00	0	530,154	4.00	
5.00	RESPIRATORY THERAPY	65.00	0	53,807	5.00	
6.00	CLINIC	90.00	0	261,889	6.00	
	TOTALS		0	2,507,775		
	O - OUTPATIENT SERVICE RECLASS					
1.00	OUTPATIENT SERVICES	90.02	750,965	21,742	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		750,965	21,742		
500.00	Grand Total: Increases		3,730,338	111,236,299	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 4:58 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CAFETERIA						1.00
	DIETARY	10.00	1,283,896	803,090	0		
	TOTALS		1,283,896	803,090			
C - DRUGS SOLD							
1.00	PHARMACY	15.00	0	41,964,460	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	41,964,460			
D - RADIOLOGY SUPPORT							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	450,425	31,286	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		450,425	31,286			
E - CHARGEABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	2,058,578	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,019,847	0		2.00
3.00	NURSERY	43.00	0	108,369	0		3.00
4.00	OPERATING ROOM	50.00	0	11,683,583	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	650,303	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	418,207	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,862,622	0		7.00
8.00	ULTRASOUND	54.01	0	212,603	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	309,540	0		9.00
10.00	CYBERKNIFE	55.01	0	2,223	0		10.00
11.00	RADIOISOTOPE	56.00	0	35,113	0		11.00
12.00	CT SCAN	57.00	0	468,226	0		12.00
13.00	MRI	58.00	0	84,835	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	3,271,896	0		14.00
15.00	LABORATORY	60.00	0	6,537,031	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	394,245	0		16.00
17.00	SLEEP LAB	65.01	0	50,991	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	11,162	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	1,523	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	233	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	193,800	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,929	0		22.00
23.00	RENAL DIALYSIS	74.00	0	20	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	5,122	0		24.00
25.00	CLINIC	90.00	0	1,458,180	0		25.00
26.00	OUTPATIENT CLINICS	90.01	0	340,263	0		26.00
27.00	EMERGENCY	91.00	0	1,300,949	0		27.00
	TOTALS		0	32,483,393			
G - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	1,091,658	115,505	0		1.00
	TOTALS		1,091,658	115,505			
I - REHAB ADMIN							
1.00	PHYSICAL THERAPY	66.00	0	908	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	460	0		2.00
	TOTALS		0	1,368			
J - IMPLANTS							
1.00	ADULTS & PEDIATRICS	30.00	0	123,210	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	7,333	0		2.00
3.00	OPERATING ROOM	50.00	0	104	0		3.00
4.00	OPERATING ROOM	50.00	0	26,724,734	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	45	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	835,360	0		6.00
7.00	ULTRASOUND	54.01	0	1,060	0		7.00
8.00	CT SCAN	57.00	0	7,455	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	4,750,534	0		9.00
12.00	CLINIC	90.00	0	21,202	0		12.00
13.00	OUTPATIENT CLINICS	90.01	0	25,257	0		13.00
14.00	EMERGENCY	91.00	0	33,093	0		14.00
	TOTALS		0	32,529,387			
K - LOMBARD POB COSTS							
1.00	OPERATION OF PLANT	7.00	32,559	240,681	0		1.00
2.00	HOUSEKEEPING	9.00	92,518	5,225	0		2.00
	TOTALS		125,077	245,906			
L - POB BUILDING COSTS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	315,246	9		1.00
2.00	OPERATION OF PLANT	7.00	28,317	217,141	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		28,317	532,387			

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6

Date/Time Prepared:
11/24/2020 4:58 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
M - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,507,775	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		0	2,507,775		
O - OUTPATIENT SERVICE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	737,506	19,899	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	13,459	1,843	0	2.00
	TOTALS		750,965	21,742		
500.00	Grand Total: Decreases		3,730,338	111,236,299		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	31,942,972	116,135	0	116,135	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	469,308,870	0	0	0	390,748	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	238,156,089	0	0	0	7,527,929	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	739,407,931	116,135	0	116,135	7,918,677	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	739,407,931	116,135	0	116,135	7,918,677	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	32,059,107	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	468,918,122	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	230,628,160	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	731,605,389	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	731,605,389	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/24/2020 4:58 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	16,495,018	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,664,232	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	27,159,250	0	0	0	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	16,495,018				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,664,232				2.00
3.00	Total (sum of lines 1-2)	0	27,159,250				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/24/2020 4:58 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	468,918,122	0	468,918,122	0.670318	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	230,628,160	0	230,628,160	0.329682	0	2.00
3.00	Total (sum of lines 1-2)	699,546,282	0	699,546,282	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	16,179,772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,443,220	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	29,622,992	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	16,179,772	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	13,443,220	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	29,622,992	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0200

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

Worksheet A-8

Date/Time Prepared:
11/24/2020 4:58 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-43,546	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,861,823			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,273,668			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,359,322	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	GOODWILL	A	-957,272	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0200

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

Worksheet A-8

Date/Time Prepared:
11/24/2020 4:58 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.04 PATIENT PHONE DEPRECIATION	A	-4,315	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05 OFFSET OCC HEALTH COSTS	A	-1,015,159	CLINIC	90.00	0	33.05
33.06 OFFSET OCC HEALTH COSTS	A	-345,279	OUTPATIENT CLINICS	90.01	0	33.06
33.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
34.00 DONATIONS	A	-125,401	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 PHYSICIAN PROFESSIONAL COMPONENT	A	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	35.00
36.01 OTHER REVENUE	B	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
36.02 OTHER REVENUE	B	-673,893	ADMINISTRATIVE & GENERAL	5.00	0	36.02
36.03 OTHER REVENUE	B	-2,060,899	OPERATION OF PLANT	7.00	0	36.03
36.04 OTHER REVENUE	B	-1,147,517	LAUNDRY & LINEN SERVICE	8.00	0	36.04
36.05 OTHER REVENUE	B	-48,310	HOUSEKEEPING	9.00	0	36.05
36.07 OTHER REVENUE	B	-148,244	NURSING ADMINISTRATION	13.00	0	36.07
36.08 OTHER REVENUE	B	-4,800	PARAMED ED PRGM-PASTORAL CARE	23.00	0	36.08
36.09 OTHER REVENUE	B	-31,428	ADULTS & PEDIATRICS	30.00	0	36.09
36.10 OTHER REVENUE	B	-4,345	INTENSIVE CARE UNIT	31.00	0	36.10
36.11 OTHER REVENUE	B	-248,220	DELIVERY ROOM & LABOR ROOM	52.00	0	36.11
36.12 OTHER REVENUE	B	-101,017	RADIOLOGY-DIAGNOSTIC	54.00	0	36.12
36.13 OTHER REVENUE	B	-433,057	CYBERKNIFE	55.01	0	36.13
36.14 OTHER REVENUE	B	-5,562,709	LABORATORY	60.00	0	36.14
36.15 OTHER REVENUE	B	-20,671	PHYSICAL THERAPY	66.00	0	36.15
36.16 OTHER REVENUE	B	-1,890,096	CLINIC	90.00	0	36.16
36.17 OTHER REVENUE	B	-975	CT SCAN	57.00	0	36.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,361,966				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0200

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

Worksheet A-8-1

Date/Time Prepared:
11/24/2020 4:58 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION EXPENSE	2,783,303	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	4,892,995	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	A & G	54,637,302	68,891,077	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	8,791,914	6,378,561	3.02
3.03	15.00	PHARMACY	RX	302,708	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2,587,748	0	3.04
3.05	13.00	NURSING ADMINISTRATION	CARDIOLOGY & ER RELATED ORG	213,207	213,207	3.05
3.06	91.00	EMERGENCY	CARDIOLOGY & ER RELATED ORG	471,804	471,804	3.06
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			74,680,981	75,954,649	5.00

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

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

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

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

6.00	B	EDWARD ELMHURST HEALTH	100.00		0.00	6.00
7.00	B	ELMHURST MEMORI	100.00		0.00	7.00
8.00	C	LINDEN OAKS HOS	100.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				0.00	100.00

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

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

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

Provider CCN: 14-0200

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

Worksheet A-8-1

Date/Time Prepared:
11/24/2020 4:58 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	11		1.00
2.00	2,783,303	9		2.00
3.00	4,892,995	0		3.00
3.01	-14,253,775	0		3.01
3.02	2,413,353	0		3.02
3.03	302,708	0		3.03
3.04	2,587,748	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
4.00	0	0		4.00
5.00	-1,273,668			5.00

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

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0200

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

Worksheet A-8-2

Date/Time Prepared:
11/24/2020 4:58 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	1,025,973	0	1,025,973	211,500	8,208	1.00
2.00	54.01	ULTRASOUND	9,400	9,400	0	0	0	2.00
3.00	57.00	CT SCAN	89,390	89,390	0	0	0	3.00
4.00	60.00	LABORATORY	488,337	488,337	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	1,674,067	1,674,067	0	0	0	5.00
6.00	90.00	CLINIC	3,085,341	3,085,341	0	0	0	6.00
7.00	90.01	OUTPATIENT CLINICS	800,588	800,588	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	2,810	2,810	0	0	0	9.00
10.00	90.00	CLINIC	477,876	477,876	0	0	0	10.00
11.00	90.01	OUTPATIENT CLINICS	42,653	42,653	0	0	0	11.00
200.00			7,696,435	6,670,462	1,025,973		8,208	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	834,612	41,731	0	0	0	1.00
2.00	54.01	ULTRASOUND	0	0	0	0	0	2.00
3.00	57.00	CT SCAN	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	OUTPATIENT CLINICS	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	90.01	OUTPATIENT CLINICS	0	0	0	0	0	11.00
200.00			834,612	41,731	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	834,612	191,361	191,361		1.00
2.00	54.01	ULTRASOUND	0	0	0	9,400		2.00
3.00	57.00	CT SCAN	0	0	0	89,390		3.00
4.00	60.00	LABORATORY	0	0	0	488,337		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,674,067		5.00
6.00	90.00	CLINIC	0	0	0	3,085,341		6.00
7.00	90.01	OUTPATIENT CLINICS	0	0	0	800,588		7.00
8.00	0.00		0	0	0	0		8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,810		9.00
10.00	90.00	CLINIC	0	0	0	477,876		10.00
11.00	90.01	OUTPATIENT CLINICS	0	0	0	42,653		11.00
200.00			0	834,612	191,361	6,861,823		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	16,179,772	16,179,772			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,443,220	13,443,220			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,353,743	182,599	14,650	24,550,992	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	119,659,020	1,117,568	4,785,255	1,920,934	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,826,437	5,489,247	1,025,632	363,043	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	686,822	68,744	103,819	177,507	8.00
9.00	00900	HOUSEKEEPING	5,335,944	102,572	40,181	706,007	9.00
10.00	01000	DIETARY	2,406,878	434,108	192,985	254,446	10.00
11.00	01100	CAFETERIA	727,664	0	0	220,629	11.00
13.00	01300	NURSING ADMINISTRATION	2,373,482	34,179	1,379	411,990	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	4,857,193	142,927	103,606	617,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,587,748	0	34,532	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	445,679	50,678	102	75,509	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,702,590	4,170,591	681,038	3,961,039	30.00
31.00	03100	INTENSIVE CARE UNIT	8,408,644	696,678	101,216	1,328,661	31.00
43.00	04300	NURSERY	3,119,135	0	2,153	436,772	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,797,121	1,307,412	1,748,159	2,121,422	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,026,851	38,824	224,881	703,957	52.00
53.00	05300	ANESTHESIOLOGY	449,784	15,983	97,593	37,146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,135,659	238,752	675,400	689,247	54.00
54.01	03630	ULTRASOUND	1,497,215	40,944	147,182	251,342	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,721,015	0	536,764	452,640	55.00
55.01	05501	CYBERKNIFE	1,586,643	0	0	85,239	55.01
56.00	05600	RADIOISOTOPE	2,335,161	65,205	22,151	93,147	56.00
57.00	05700	CT SCAN	1,530,444	63,656	102,346	200,134	57.00
58.00	05800	MRI	1,015,060	93,982	336,620	152,235	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,984,440	411,765	346,822	396,915	59.00
60.00	06000	LABORATORY	5,504,977	383,375	683,380	1,129,307	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,575,216	61,167	49,434	358,257	65.00
65.01	03610	SLEEP LAB	472,227	0	7,837	69,423	65.01
66.00	06600	PHYSICAL THERAPY	3,215,917	0	21,148	550,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	846,510	46,770	3,072	145,002	67.00
68.00	06800	SPEECH PATHOLOGY	337,366	0	0	57,725	68.00
69.00	06900	ELECTROCARDIOLOGY	935,636	0	80,915	153,036	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	341,811	0	3,262	58,574	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,483,393	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,523,427	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,115,543	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	872,787	4,074	626	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	483,590	0	52,932	81,601	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	30,082,872	16,997	1,006,874	4,079,677	90.00
90.01	09001	OUTPATIENT CLINICS	2,265,611	0	30,345	440,913	90.01
90.02	09003	OUTPATIENT SERVICES	772,707	0	0	129,048	90.02
91.00	09100	EMERGENCY	8,100,039	818,386	167,124	1,180,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	442,122,993	16,097,183	13,431,415	24,091,220	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	946,992	57,296	10,547	57,777	190.00
190.01	19001	FOUNDATION	517,634	25,293	0	87,233	190.01
191.00	19100	RESEARCH	147,716	0	0	24,882	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,481,303	0	1,258	26,360	192.00
192.01	19201	SCHOOL NURSES	1,534,327	0	0	263,520	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	446,750,965	16,179,772	13,443,220	24,550,992	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 4:58 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	127,482,777					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	8,267,188	0	28,971,547			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414,028	0	212,093	1,663,013		8.00
9.00	00900	HOUSEKEEPING	2,469,534	0	316,461	12,630	8,983,329	9.00
10.00	01000	DIETARY	1,313,055	0	1,339,329	0	423,009	10.00
11.00	01100	CAFETERIA	378,651	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,126,429	0	105,449	0	33,305	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,284,405	0	440,964	0	139,272	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,047,069	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	228,385	0	156,354	0	49,382	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,382,542	0	12,867,292	322,264	4,063,956	30.00
31.00	03100	INTENSIVE CARE UNIT	4,206,673	0	2,149,422	87,305	678,865	31.00
43.00	04300	NURSERY	1,420,723	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,774,198	0	4,033,685	157,471	1,273,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,994,294	0	119,782	0	37,832	52.00
53.00	05300	ANESTHESIOLOGY	239,780	0	49,312	0	15,575	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,291,589	0	736,608	62,419	232,648	54.00
54.01	03630	ULTRASOUND	773,312	0	126,323	930	39,897	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,481,559	0	0	2,411	0	55.00
55.01	05501	CYBERKNIFE	667,577	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	1,004,497	0	201,172	12,195	63,538	56.00
57.00	05700	CT SCAN	757,299	0	196,395	8,158	62,029	57.00
58.00	05800	MRI	638,035	0	289,957	21,372	91,579	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,653,066	0	1,270,395	22,669	401,237	59.00
60.00	06000	LABORATORY	3,075,002	0	1,182,805	296	373,573	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,215,490	0	188,716	0	59,603	65.00
65.01	03610	SLEEP LAB	219,409	0	0	4,088	0	65.01
66.00	06600	PHYSICAL THERAPY	1,512,420	0	0	3,512	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	415,810	0	144,296	0	45,574	67.00
68.00	06800	SPEECH PATHOLOGY	157,759	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	467,013	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	161,175	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,970,521	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,986,507	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,219,365	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	350,378	0	12,570	1,936	3,970	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	246,815	0	0	484	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	14,049,832	0	52,440	14,982	16,563	90.00
90.01	09001	OUTPATIENT CLINICS	1,092,824	0	0	18,760	0	90.01
90.02	09003	OUTPATIENT SERVICES	360,068	0	0	7,552	0	90.02
91.00	09100	EMERGENCY	4,099,288	0	2,524,920	153,035	797,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,413,564	0	28,716,740	914,469	8,902,852	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	428,291	0	176,772	9,068	55,831	190.00
190.01	19001	FOUNDATION	251,621	0	78,035	0	24,646	190.01
191.00	19100	RESEARCH	68,918	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	602,508	0	0	739,476	0	192.00
192.01	19201	SCHOOL NURSES	717,875	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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)	127,482,777	0	28,971,547	1,663,013	8,983,329	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,363,810					10.00
11.00	01100	CAFETERIA	0	1,326,944				11.00
13.00	01300	NURSING ADMINISTRATION	0	13,269	4,099,482			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	27,793	0	0	8,613,501	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
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	6,507	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,594,294	249,000	1,572,899	0	29,298	30.00
31.00	03100	INTENSIVE CARE UNIT	580,575	69,699	440,278	0	10,624	31.00
43.00	04300	NURSERY	0	21,351	134,873	0	86	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	130,438	823,963	0	41,839	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,941	38,268	241,734	0	6,677	52.00
53.00	05300	ANESTHESIOLOGY	0	3,097	19,561	0	36,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,601	0	0	358	54.00
54.01	03630	ULTRASOUND	0	12,501	0	0	112	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	24,530	154,956	0	5,818	55.00
55.01	05501	CYBERKNIFE	0	3,094	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	4,503	0	0	321,402	56.00
57.00	05700	CT SCAN	0	11,003	0	0	21,308	57.00
58.00	05800	MRI	0	7,745	0	0	15	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,972	0	0	1,734	59.00
60.00	06000	LABORATORY	0	85,683	0	0	95,221	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	22,345	0	0	0	65.00
65.01	03610	SLEEP LAB	0	4,804	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	33,938	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,845	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,363	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,655	0	0	1,057	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,474	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,945,443	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	5,838	36,876	0	1	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	329,680	0	0	1,080,238	90.00
90.01	09001	OUTPATIENT CLINICS	0	20,791	131,333	0	1,897	90.01
90.02	09003	OUTPATIENT SERVICES	0	8,059	50,909	0	0	90.02
91.00	09100	EMERGENCY	0	77,903	492,100	0	13,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,363,810	1,291,749	4,099,482	0	8,613,501	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,401	0	0	0	190.00
190.01	19001	FOUNDATION	0	4,552	0	0	0	190.01
191.00	19100	RESEARCH	0	643	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,045	0	0	0	192.00
192.01	19201	SCHOOL NURSES	0	20,554	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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)	6,363,810	1,326,944	4,099,482	0	8,613,501	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	3,669,349					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	0	1,012,596			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	279,081	0	587,754	72,463,638	0	30.00
31.00	03100	INTENSIVE CARE UNIT	69,220	0	159,715	18,987,575	0	31.00
43.00	04300	NURSERY	33,575	0	0	5,168,668	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	322,122	0	0	37,531,814	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,482	0	0	7,673,523	0	52.00
53.00	05300	ANESTHESIOLOGY	137,969	0	0	1,102,678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,057	0	0	9,239,338	0	54.00
54.01	03630	ULTRASOUND	58,424	0	0	2,948,182	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	97,618	0	0	5,477,311	0	55.00
55.01	05501	CYBERKNIFE	12,086	0	0	2,354,639	0	55.01
56.00	05600	RADIOISOTOPE	38,471	0	0	4,161,442	0	56.00
57.00	05700	CT SCAN	221,014	0	0	3,173,786	0	57.00
58.00	05800	MRI	73,037	0	0	2,719,637	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	105,492	0	0	7,613,507	0	59.00
60.00	06000	LABORATORY	369,743	0	0	12,883,362	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	52,981	0	0	4,583,209	0	65.00
65.01	03610	SLEEP LAB	10,685	0	0	788,473	0	65.01
66.00	06600	PHYSICAL THERAPY	41,520	0	0	5,379,096	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,024	0	0	1,666,903	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,110	0	0	560,323	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,327	0	0	1,681,639	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,186	0	0	575,482	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	145,071	0	0	45,598,985	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	247,217	0	0	45,757,151	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	590,600	0	0	60,870,951	0	73.00
74.00	07400	RENAL DIALYSIS	7,152	0	0	1,253,493	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	10,243	0	0	918,380	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	142,062	0	0	50,872,217	0	90.00
90.01	09001	OUTPATIENT CLINICS	21,651	0	105,412	4,129,537	0	90.01
90.02	09003	OUTPATIENT SERVICES	10,400	0	0	1,338,743	0	90.02
91.00	09100	EMERGENCY	322,729	0	159,715	18,906,909	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,669,349	0	1,012,596	438,380,591	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,748,975	0	190.00
190.01	19001	FOUNDATION	0	0	0	989,014	0	190.01
191.00	19100	RESEARCH	0	0	0	242,159	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,853,950	0	192.00
192.01	19201	SCHOOL NURSES	0	0	0	2,536,276	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	0	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)	3,669,349	0	1,012,596	446,750,965	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
55.01	05501	CYBERKNIFE	55.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03610	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	ACUPUNCTURE	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT CLINICS	90.01
90.02	09003	OUTPATIENT SERVICES	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	FOUNDATION	190.01
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL NURSES	192.01
194.00	07950	OUTPATIENT PHARMACY	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 4:58 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	182,599	14,650	197,249	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	410,703	1,117,568	4,785,255	6,313,526	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	98,038	5,489,247	1,025,632	6,612,917	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,711	68,744	103,819	193,274	8.00
9.00	00900	HOUSEKEEPING	5,307	102,572	40,181	148,060	9.00
10.00	01000	DIETARY	19,652	434,108	192,985	646,745	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	34,179	1,379	35,558	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	821,464	142,927	103,606	1,067,997	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	34,532	34,532	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	50,678	102	50,780	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,211	4,170,591	681,038	4,876,840	30.00
31.00	03100	INTENSIVE CARE UNIT	5,797	696,678	101,216	803,691	31.00
43.00	04300	NURSERY	10,365	0	2,153	12,518	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,204,501	1,307,412	1,748,159	4,260,072	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,098	38,824	224,881	286,803	52.00
53.00	05300	ANESTHESIOLOGY	2,694	15,983	97,593	116,270	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,823	238,752	675,400	917,975	54.00
54.01	03630	ULTRASOUND	2,782	40,944	147,182	190,908	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	8,760	0	536,764	545,524	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	65,205	22,151	87,356	56.00
57.00	05700	CT SCAN	0	63,656	102,346	166,002	57.00
58.00	05800	MRI	5,696	93,982	336,620	436,298	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,652	411,765	346,822	783,239	59.00
60.00	06000	LABORATORY	45,374	383,375	683,380	1,112,129	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	76,951	61,167	49,434	187,552	65.00
65.01	03610	SLEEP LAB	0	0	7,837	7,837	65.01
66.00	06600	PHYSICAL THERAPY	8,145	0	21,148	29,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	46,770	3,072	49,842	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	80,915	80,915	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,262	3,262	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,074	626	4,700	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,884	0	52,932	55,816	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	5,752,930	16,997	1,006,874	6,776,801	90.00
90.01	09001	OUTPATIENT CLINICS	6,446	0	30,345	36,791	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	0	90.02
91.00	09100	EMERGENCY	25,833	818,386	167,124	1,011,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,611,817	16,097,183	13,431,415	38,140,415	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,144	57,296	10,547	76,987	190.00
190.01	19001	FOUNDATION	0	25,293	0	25,293	190.01
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,144	0	1,258	10,402	192.00
192.01	19201	SCHOOL NURSES	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,630,105	16,179,772	13,443,220	38,253,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/24/2020 4:58 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	6,328,963					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	410,423	0	7,026,258			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,554	0	51,437	266,692		8.00
9.00	00900	HOUSEKEEPING	122,599	0	76,749	2,025	355,107	9.00
10.00	01000	DIETARY	65,186	0	324,818	0	16,721	10.00
11.00	01100	CAFETERIA	18,798	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	55,921	0	25,574	0	1,317	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	113,409	0	106,944	0	5,505	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,981	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	11,338	0	37,919	0	1,952	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	664,373	0	3,120,611	51,680	160,647	30.00
31.00	03100	INTENSIVE CARE UNIT	208,839	0	521,284	14,001	26,835	31.00
43.00	04300	NURSERY	70,531	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	435,593	0	978,260	25,253	50,360	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,006	0	29,050	0	1,495	52.00
53.00	05300	ANESTHESIOLOGY	11,904	0	11,959	0	616	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,765	0	178,644	10,010	9,196	54.00
54.01	03630	ULTRASOUND	38,391	0	30,636	149	1,577	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	73,552	0	0	387	0	55.00
55.01	05501	CYBERKNIFE	33,142	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	49,868	0	48,789	1,956	2,512	56.00
57.00	05700	CT SCAN	37,596	0	47,630	1,308	2,452	57.00
58.00	05800	MRI	31,675	0	70,321	3,427	3,620	58.00
59.00	05900	CARDIAC CATHETERIZATION	82,066	0	308,100	3,635	15,861	59.00
60.00	06000	LABORATORY	152,658	0	286,857	47	14,767	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	60,343	0	45,768	0	2,356	65.00
65.01	03610	SLEEP LAB	10,892	0	0	656	0	65.01
66.00	06600	PHYSICAL THERAPY	75,084	0	0	563	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,643	0	34,995	0	1,802	67.00
68.00	06800	SPEECH PATHOLOGY	7,832	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,185	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,001	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,918	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	644,712	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	755,677	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	17,394	0	3,048	310	157	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,253	0	0	78	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	697,500	0	12,718	2,403	655	90.00
90.01	09001	OUTPATIENT CLINICS	54,253	0	0	3,009	0	90.01
90.02	09003	OUTPATIENT SERVICES	17,875	0	0	1,211	0	90.02
91.00	09100	EMERGENCY	203,508	0	612,351	24,542	31,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,226,238	0	6,964,462	146,650	351,926	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,262	0	42,871	1,454	2,207	190.00
190.01	19001	FOUNDATION	12,492	0	18,925	0	974	190.01
191.00	19100	RESEARCH	3,421	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,911	0	0	118,588	0	192.00
192.01	19201	SCHOOL NURSES	35,639	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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)	6,328,963	0	7,026,258	266,692	355,107	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,055,515					10.00
11.00	01100	CAFETERIA	0	20,571				11.00
13.00	01300	NURSING ADMINISTRATION	0	206	121,887			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	431	0	0	1,299,247	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
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	101	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	927,882	3,860	46,767	0	4,419	30.00
31.00	03100	INTENSIVE CARE UNIT	96,295	1,080	13,090	0	1,603	31.00
43.00	04300	NURSERY	0	331	4,010	0	13	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,022	24,498	0	6,311	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,338	593	7,187	0	1,007	52.00
53.00	05300	ANESTHESIOLOGY	0	48	582	0	5,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	629	0	0	54	54.00
54.01	03630	ULTRASOUND	0	194	0	0	17	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	380	4,607	0	878	55.00
55.01	05501	CYBERKNIFE	0	48	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	70	0	0	48,480	56.00
57.00	05700	CT SCAN	0	171	0	0	3,214	57.00
58.00	05800	MRI	0	120	0	0	2	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	294	0	0	262	59.00
60.00	06000	LABORATORY	0	1,328	0	0	14,363	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	346	0	0	0	65.00
65.01	03610	SLEEP LAB	0	74	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	526	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	106	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	37	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	134	0	0	159	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	38	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,047,638	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	90	1,096	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	5,113	0	0	162,942	90.00
90.01	09001	OUTPATIENT CLINICS	0	322	3,905	0	286	90.01
90.02	09003	OUTPATIENT SERVICES	0	125	1,514	0	0	90.02
91.00	09100	EMERGENCY	0	1,208	14,631	0	2,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,055,515	20,025	121,887	0	1,299,247	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99	0	0	0	190.00
190.01	19001	FOUNDATION	0	71	0	0	0	190.01
191.00	19100	RESEARCH	0	10	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	47	0	0	0	192.00
192.01	19201	SCHOOL NURSES	0	319	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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)	1,055,515	20,571	121,887	0	1,299,247	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	86,513					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	0	102,697			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,674	0		9,895,586	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,655	0		1,699,051	0	31.00
43.00	04300	NURSERY	803	0		91,716	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,703	0		5,807,121	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,231	0		463,367	0	52.00
53.00	05300	ANESTHESIOLOGY	3,299	0		150,540	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,254	0		1,239,066	0	54.00
54.01	03630	ULTRASOUND	1,397	0		265,289	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,334	0		631,300	0	55.00
55.01	05501	CYBERKNIFE	289	0		34,164	0	55.01
56.00	05600	RADIOISOTOPE	920	0		240,700	0	56.00
57.00	05700	CT SCAN	5,285	0		265,266	0	57.00
58.00	05800	MRI	1,747	0		548,433	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,523	0		1,199,170	0	59.00
60.00	06000	LABORATORY	8,842	0		1,600,067	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,267	0		300,511	0	65.00
65.01	03610	SLEEP LAB	256	0		20,273	0	65.01
66.00	06600	PHYSICAL THERAPY	993	0		110,884	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	311	0		108,864	0	67.00
68.00	06800	SPEECH PATHOLOGY	122	0		8,455	0	68.00
69.00	06900	ELECTROCARDIOLOGY	845	0		106,468	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	196	0		11,968	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,469	0		647,387	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,912	0		650,624	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,889	0		1,816,204	0	73.00
74.00	07400	RENAL DIALYSIS	171	0		25,780	0	74.00
76.00	03020	ACUPUNCTURE	0	0		0	0	76.00
76.97	07697	CARDIAC REHABILITATION	245	0		70,234	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	3,397	0		7,694,259	0	90.00
90.01	09001	OUTPATIENT CLINICS	518	0		102,627	0	90.01
90.02	09003	OUTPATIENT SERVICES	249	0		22,011	0	90.02
91.00	09100	EMERGENCY	7,717	0		1,918,348	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,513	0	0	37,745,733	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		145,344	0	190.00
190.01	19001	FOUNDATION	0	0		58,456	0	190.01
191.00	19100	RESEARCH	0	0		3,631	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		159,160	0	192.00
192.01	19201	SCHOOL NURSES	0	0		38,076	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0		0	0	194.00
200.00		Cross Foot Adjustments			102,697	102,697	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,513	0	102,697	38,253,097	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
55.01	05501	CYBERKNIFE	55.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03610	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	ACUPUNCTURE	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT CLINICS	90.01
90.02	09003	OUTPATIENT SERVICES	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	FOUNDATION	190.01
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL NURSES	192.01
194.00	07950	OUTPATIENT PHARMACY	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

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 (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	877,665					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,664,731				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,905	11,622	142,868,858			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,622	3,796,224	11,178,424	-127,482,777	319,268,188	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	297,762	813,651	2,112,644	0	20,704,359	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,729	82,361	1,032,959	0	1,036,892	8.00
9.00	00900	HOUSEKEEPING	5,564	31,876	4,108,441	0	6,184,704	9.00
10.00	01000	DIETARY	23,548	153,098	1,480,691	0	3,288,417	10.00
11.00	01100	CAFETERIA	0	0	1,283,896	0	948,293	11.00
13.00	01300	NURSING ADMINISTRATION	1,854	1,094	2,397,479	0	2,821,030	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	7,753	82,192	3,592,470	0	5,721,067	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,395	0	0	2,622,280	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	2,749	81	439,407	0	571,968	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	226,232	540,279	23,050,338	0	33,515,258	30.00
31.00	03100	INTENSIVE CARE UNIT	37,791	80,296	7,731,830	0	10,535,199	31.00
43.00	04300	NURSERY	0	1,708	2,541,692	0	3,558,060	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,920	1,386,843	12,345,117	0	21,974,114	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,106	178,402	4,096,515	0	4,994,513	52.00
53.00	05300	ANESTHESIOLOGY	867	77,422	216,161	0	600,506	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,951	535,806	4,010,909	0	5,739,058	54.00
54.01	03630	ULTRASOUND	2,221	116,762	1,462,628	0	1,936,683	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	425,824	2,634,032	0	3,710,419	55.00
55.01	05501	CYBERKNIFE	0	0	496,029	0	1,671,882	55.01
56.00	05600	RADIOISOTOPE	3,537	17,573	542,045	0	2,515,664	56.00
57.00	05700	CT SCAN	3,453	81,193	1,164,633	0	1,896,580	57.00
58.00	05800	MRI	5,098	267,046	885,897	0	1,597,897	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,336	275,140	2,309,754	0	4,139,942	59.00
60.00	06000	LABORATORY	20,796	542,137	6,571,738	0	7,701,039	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,318	39,217	2,084,792	0	3,044,074	65.00
65.01	03610	SLEEP LAB	0	6,217	403,990	0	549,487	65.01
66.00	06600	PHYSICAL THERAPY	0	16,777	3,204,326	0	3,787,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,537	2,437	843,805	0	1,041,354	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	335,915	0	395,091	68.00
69.00	06900	ELECTROCARDIOLOGY	0	64,191	890,558	0	1,169,587	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,588	340,860	0	403,647	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	32,483,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32,523,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	38,115,543	73.00
74.00	07400	RENAL DIALYSIS	221	497	0	0	877,487	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	41,992	474,856	0	618,123	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	922	798,770	23,740,848	0	35,186,420	90.00
90.01	09001	OUTPATIENT CLINICS	0	24,073	2,565,791	0	2,736,869	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	750,965	0	901,755	90.02
91.00	09100	EMERGENCY	44,393	132,582	6,870,889	0	10,266,263	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	873,185	10,655,366	140,193,324	-127,482,777	314,086,050	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,108	8,367	336,217	0	1,072,612	190.00
190.01	19001	FOUNDATION	1,372	0	507,634	0	630,160	190.01
191.00	19100	RESEARCH	0	0	144,797	0	172,598	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	998	153,394	0	1,508,921	192.00
192.01	19201	SCHOOL NURSES	0	0	1,533,492	0	1,797,847	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

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 (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	16,179,772	13,443,220	24,550,992		127,482,777	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.435020	1.260531	0.171843		0.399297	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			197,249		6,328,963	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001381		0.019823	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: 14-0200

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

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 (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	509,376				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,729	3,846,292			8.00
9.00	00900	HOUSEKEEPING	0	5,564	29,212	500,083		9.00
10.00	01000	DIETARY	0	23,548	0	23,548	193,904	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,854	0	1,854	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	7,753	0	7,753	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
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	2,749	0	2,749	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	226,232	745,346	226,232	170,457	30.00
31.00	03100	INTENSIVE CARE UNIT	0	37,791	201,922	37,791	17,690	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	70,920	364,206	70,920	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,106	0	2,106	5,757	52.00
53.00	05300	ANESTHESIOLOGY	0	867	0	867	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,951	144,366	12,951	0	54.00
54.01	03630	ULTRASOUND	0	2,221	2,150	2,221	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	5,577	0	0	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	3,537	28,205	3,537	0	56.00
57.00	05700	CT SCAN	0	3,453	18,869	3,453	0	57.00
58.00	05800	MRI	0	5,098	49,429	5,098	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	22,336	52,429	22,336	0	59.00
60.00	06000	LABORATORY	0	20,796	684	20,796	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,318	0	3,318	0	65.00
65.01	03610	SLEEP LAB	0	0	9,454	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	8,123	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,537	0	2,537	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	221	4,477	221	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,119	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	922	34,652	922	0	90.00
90.01	09001	OUTPATIENT CLINICS	0	0	43,390	0	0	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	17,467	0	0	90.02
91.00	09100	EMERGENCY	0	44,393	353,946	44,393	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	504,896	2,115,023	495,603	193,904	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,108	20,972	3,108	0	190.00
190.01	19001	FOUNDATION	0	1,372	0	1,372	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,710,297	0	0	192.00
192.01	19201	SCHOOL NURSES	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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	28,971,547	1,663,013	8,983,329	6,363,810	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	56.876545	0.432368	17.963676	32.819385	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	7,026,258	266,692	355,107	1,055,515	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	13.793854	0.069337	0.710096	5.443493	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: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description			CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,791,054					11.00
13.00	01300	NURSING ADMINISTRATION	37,909	1,854,104				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	79,405	0	0	47,307,334		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,658,065,665	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	18,591	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	711,387	711,387	0	160,909	202,232,713	30.00
31.00	03100	INTENSIVE CARE UNIT	199,128	199,128	0	58,352	50,159,346	31.00
43.00	04300	NURSERY	61,000	61,000	0	470	24,329,655	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	372,660	372,660	0	229,791	233,421,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,331	109,331	0	36,673	37,305,872	52.00
53.00	05300	ANESTHESIOLOGY	8,847	8,847	0	202,544	99,977,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,995	0	0	1,965	98,592,049	54.00
54.01	03630	ULTRASOUND	35,716	0	0	614	42,336,559	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	70,083	70,083	0	31,956	70,737,683	55.00
55.01	05501	CYBERKNIFE	8,840	0	0	0	8,758,087	55.01
56.00	05600	RADIOISOTOPE	12,866	0	0	1,765,217	27,877,568	56.00
57.00	05700	CT SCAN	31,436	0	0	117,026	160,155,089	57.00
58.00	05800	MRI	22,126	0	0	83	52,925,076	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,204	0	0	9,524	76,443,662	59.00
60.00	06000	LABORATORY	244,795	0	0	522,979	267,929,825	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	63,839	0	0	0	38,392,269	65.00
65.01	03610	SLEEP LAB	13,725	0	0	0	7,742,900	65.01
66.00	06600	PHYSICAL THERAPY	96,960	0	0	0	30,087,173	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,556	0	0	0	9,437,980	67.00
68.00	06800	SPEECH PATHOLOGY	6,750	0	0	0	3,702,999	68.00
69.00	06900	ELECTROCARDIOLOGY	24,726	0	0	5,807	25,599,153	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,069	0	0	0	5,932,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	105,123,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	179,142,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,145,949	427,086,739	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	5,182,806	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	16,678	16,678	0	7	7,422,152	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	941,892	0	0	5,932,930	102,943,560	90.00
90.01	09001	OUTPATIENT CLINICS	59,399	59,399	0	10,419	15,689,458	90.01
90.02	09003	OUTPATIENT SERVICES	23,025	23,025	0	0	7,536,345	90.02
91.00	09100	EMERGENCY	222,566	222,566	0	74,119	233,861,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,690,504	1,854,104	0	47,307,334	2,658,065,665	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,287	0	0	0	0	190.00
190.01	19001	FOUNDATION	13,006	0	0	0	0	190.01
191.00	19100	RESEARCH	1,837	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,699	0	0	0	0	192.00
192.01	19201	SCHOOL NURSES	58,721	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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)	1,326,944	4,099,482	0	8,613,501	3,669,349	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.350020	2.211031	0.000000	0.182075	0.001380	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	20,571	121,887	0	1,299,247	86,513	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.005426	0.065739	0.000000	0.027464	0.000033	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: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description			SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM-PASTORAL CARE (ASSIGNED TIME)	
			17.00	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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	317	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	184	30.00
31.00	03100	INTENSIVE CARE UNIT	0	50	31.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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	03630	ULTRASOUND	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	CYBERKNIFE	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03610	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
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	0	90.00
90.01	09001	OUTPATIENT CLINICS	0	33	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	90.02
91.00	09100	EMERGENCY	0	50	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	317	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	FOUNDATION	0	0	190.01
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	SCHOOL NURSES	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	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	1,012,596	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	3,194.309148	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM-PASTORAL CARE (ASSIGNED TIME)	
		17.00	23.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	102,697	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	323.965300	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	72,463,638		72,463,638	0	72,463,638	30.00
31.00	03100	INTENSIVE CARE UNIT	18,987,575		18,987,575	0	18,987,575	31.00
43.00	04300	NURSERY	5,168,668		5,168,668	0	5,168,668	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,531,814		37,531,814	0	37,531,814	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,673,523		7,673,523	0	7,673,523	52.00
53.00	05300	ANESTHESIOLOGY	1,102,678		1,102,678	0	1,102,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,239,338		9,239,338	0	9,239,338	54.00
54.01	03630	ULTRASOUND	2,948,182		2,948,182	0	2,948,182	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,477,311		5,477,311	0	5,477,311	55.00
55.01	05501	CYBERKNIFE	2,354,639		2,354,639	0	2,354,639	55.01
56.00	05600	RADIOISOTOPE	4,161,442		4,161,442	0	4,161,442	56.00
57.00	05700	CT SCAN	3,173,786		3,173,786	0	3,173,786	57.00
58.00	05800	MRI	2,719,637		2,719,637	0	2,719,637	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,613,507		7,613,507	0	7,613,507	59.00
60.00	06000	LABORATORY	12,883,362		12,883,362	0	12,883,362	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,583,209	0	4,583,209	0	4,583,209	65.00
65.01	03610	SLEEP LAB	788,473	0	788,473	0	788,473	65.01
66.00	06600	PHYSICAL THERAPY	5,379,096	0	5,379,096	0	5,379,096	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,666,903	0	1,666,903	0	1,666,903	67.00
68.00	06800	SPEECH PATHOLOGY	560,323	0	560,323	0	560,323	68.00
69.00	06900	ELECTROCARDIOLOGY	1,681,639		1,681,639	0	1,681,639	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	575,482		575,482	0	575,482	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,598,985		45,598,985	0	45,598,985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,757,151		45,757,151	0	45,757,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,870,951		60,870,951	0	60,870,951	73.00
74.00	07400	RENAL DIALYSIS	1,253,493		1,253,493	0	1,253,493	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	918,380		918,380	0	918,380	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	50,872,217		50,872,217	0	50,872,217	90.00
90.01	09001	OUTPATIENT CLINICS	4,129,537		4,129,537	0	4,129,537	90.01
90.02	09003	OUTPATIENT SERVICES	1,338,743		1,338,743	0	1,338,743	90.02
91.00	09100	EMERGENCY	18,906,909		18,906,909	0	18,906,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,703,002		6,703,002	0	6,703,002	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	445,083,593	0	445,083,593	0	445,083,593	200.00
201.00		Less Observation Beds	6,703,002		6,703,002		6,703,002	201.00
202.00		Total (see instructions)	438,380,591	0	438,380,591	0	438,380,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 4:58 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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	186,044,095		186,044,095			30.00	
31.00	03100	INTENSIVE CARE UNIT	50,159,346		50,159,346			31.00	
43.00	04300	NURSERY	24,329,655		24,329,655			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	124,945,265	108,476,480	233,421,745	0.160790	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,051,498	5,254,374	37,305,872	0.205692	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	48,531,076	51,446,183	99,977,259	0.011029	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,275,481	72,316,568	98,592,049	0.093713	0.000000	54.00	
54.01	03630	ULTRASOUND	6,609,561	35,726,998	42,336,559	0.069637	0.000000	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	239,152	70,498,531	70,737,683	0.077431	0.000000	55.00	
55.01	05501	CYBERKNIFE	0	8,758,087	8,758,087	0.268853	0.000000	55.01	
56.00	05600	RADIOISOTOPE	3,843,839	24,033,729	27,877,568	0.149276	0.000000	56.00	
57.00	05700	CT SCAN	42,285,752	117,869,337	160,155,089	0.019817	0.000000	57.00	
58.00	05800	MRI	9,375,987	43,549,089	52,925,076	0.051387	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	34,608,701	41,834,961	76,443,662	0.099596	0.000000	59.00	
60.00	06000	LABORATORY	77,161,558	190,768,267	267,929,825	0.048085	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	34,401,156	3,991,113	38,392,269	0.119378	0.000000	65.00	
65.01	03610	SLEEP LAB	0	7,742,900	7,742,900	0.101832	0.000000	65.01	
66.00	06600	PHYSICAL THERAPY	13,188,850	16,898,323	30,087,173	0.178784	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	7,556,507	1,881,473	9,437,980	0.176617	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	3,542,657	160,342	3,702,999	0.151316	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	10,826,025	14,773,128	25,599,153	0.065691	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	4,960,597	971,468	5,932,065	0.097012	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,298,101	41,825,505	105,123,606	0.433765	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	129,394,031	49,748,765	179,142,796	0.255423	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	149,940,379	277,146,360	427,086,739	0.142526	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	4,755,203	427,603	5,182,806	0.241856	0.000000	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	395,317	7,026,835	7,422,152	0.123735	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	319,709	102,623,851	102,943,560	0.494176	0.000000	90.00	
90.01	09001	OUTPATIENT CLINICS	840,130	14,849,328	15,689,458	0.263205	0.000000	90.01	
90.02	09003	OUTPATIENT SERVICES	0	7,536,345	7,536,345	0.177638	0.000000	90.02	
91.00	09100	EMERGENCY	61,038,208	172,823,268	233,861,476	0.080847	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,732,063	14,456,555	16,188,618	0.414056	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	1,152,649,899	1,505,415,766	2,658,065,665			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	1,152,649,899	1,505,415,766	2,658,065,665			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 4:58 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	0.160790		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205692		52.00
53.00	05300	ANESTHESIOLOGY	0.011029		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093713		54.00
54.01	03630	ULTRASOUND	0.069637		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.077431		55.00
55.01	05501	CYBERKNIFE	0.268853		55.01
56.00	05600	RADIOISOTOPE	0.149276		56.00
57.00	05700	CT SCAN	0.019817		57.00
58.00	05800	MRI	0.051387		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099596		59.00
60.00	06000	LABORATORY	0.048085		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.119378		65.00
65.01	03610	SLEEP LAB	0.101832		65.01
66.00	06600	PHYSICAL THERAPY	0.178784		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176617		67.00
68.00	06800	SPEECH PATHOLOGY	0.151316		68.00
69.00	06900	ELECTROCARDIOLOGY	0.065691		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.097012		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433765		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255423		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142526		73.00
74.00	07400	RENAL DIALYSIS	0.241856		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.123735		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	0.494176		90.00
90.01	09001	OUTPATIENT CLINICS	0.263205		90.01
90.02	09003	OUTPATIENT SERVICES	0.177638		90.02
91.00	09100	EMERGENCY	0.080847		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.414056		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,463,638		72,463,638	0
31.00	03100	INTENSIVE CARE UNIT	18,987,575		18,987,575	0
43.00	04300	NURSERY	5,168,668		5,168,668	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,531,814		37,531,814	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,673,523		7,673,523	0
53.00	05300	ANESTHESIOLOGY	1,102,678		1,102,678	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,239,338		9,239,338	0
54.01	03630	ULTRASOUND	2,948,182		2,948,182	0
55.00	05500	RADIOLOGY-THERAPEUTIC	5,477,311		5,477,311	0
55.01	05501	CYBERKNIFE	2,354,639		2,354,639	0
56.00	05600	RADIOISOTOPE	4,161,442		4,161,442	0
57.00	05700	CT SCAN	3,173,786		3,173,786	0
58.00	05800	MRI	2,719,637		2,719,637	0
59.00	05900	CARDIAC CATHETERIZATION	7,613,507		7,613,507	0
60.00	06000	LABORATORY	12,883,362		12,883,362	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	4,583,209	0	4,583,209	0
65.01	03610	SLEEP LAB	788,473	0	788,473	0
66.00	06600	PHYSICAL THERAPY	5,379,096	0	5,379,096	0
67.00	06700	OCCUPATIONAL THERAPY	1,666,903	0	1,666,903	0
68.00	06800	SPEECH PATHOLOGY	560,323	0	560,323	0
69.00	06900	ELECTROCARDIOLOGY	1,681,639		1,681,639	0
70.00	07000	ELECTROENCEPHALOGRAPHY	575,482		575,482	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,598,985		45,598,985	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,757,151		45,757,151	0
73.00	07300	DRUGS CHARGED TO PATIENTS	60,870,951		60,870,951	0
74.00	07400	RENAL DIALYSIS	1,253,493		1,253,493	0
76.00	03020	ACUPUNCTURE	0		0	0
76.97	07697	CARDIAC REHABILITATION	918,380		918,380	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	50,872,217		50,872,217	0
90.01	09001	OUTPATIENT CLINICS	4,129,537		4,129,537	0
90.02	09003	OUTPATIENT SERVICES	1,338,743		1,338,743	0
91.00	09100	EMERGENCY	18,906,909		18,906,909	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,703,002		6,703,002	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	445,083,593	0	445,083,593	0
201.00		Less Observation Beds	6,703,002		6,703,002	0
202.00		Total (see instructions)	438,380,591	0	438,380,591	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	186,044,095		186,044,095			30.00
31.00	03100	INTENSIVE CARE UNIT	50,159,346		50,159,346			31.00
43.00	04300	NURSERY	24,329,655		24,329,655			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	124,945,265	108,476,480	233,421,745	0.160790	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,051,498	5,254,374	37,305,872	0.205692	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	48,531,076	51,446,183	99,977,259	0.011029	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,275,481	72,316,568	98,592,049	0.093713	0.000000	54.00
54.01	03630	ULTRASOUND	6,609,561	35,726,998	42,336,559	0.069637	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	239,152	70,498,531	70,737,683	0.077431	0.000000	55.00
55.01	05501	CYBERKNIFE	0	8,758,087	8,758,087	0.268853	0.000000	55.01
56.00	05600	RADIOISOTOPE	3,843,839	24,033,729	27,877,568	0.149276	0.000000	56.00
57.00	05700	CT SCAN	42,285,752	117,869,337	160,155,089	0.019817	0.000000	57.00
58.00	05800	MRI	9,375,987	43,549,089	52,925,076	0.051387	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,608,701	41,834,961	76,443,662	0.099596	0.000000	59.00
60.00	06000	LABORATORY	77,161,558	190,768,267	267,929,825	0.048085	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	34,401,156	3,991,113	38,392,269	0.119378	0.000000	65.00
65.01	03610	SLEEP LAB	0	7,742,900	7,742,900	0.101832	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	13,188,850	16,898,323	30,087,173	0.178784	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,556,507	1,881,473	9,437,980	0.176617	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,542,657	160,342	3,702,999	0.151316	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,826,025	14,773,128	25,599,153	0.065691	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,960,597	971,468	5,932,065	0.097012	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,298,101	41,825,505	105,123,606	0.433765	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	129,394,031	49,748,765	179,142,796	0.255423	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,940,379	277,146,360	427,086,739	0.142526	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,755,203	427,603	5,182,806	0.241856	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	395,317	7,026,835	7,422,152	0.123735	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	319,709	102,623,851	102,943,560	0.494176	0.000000	90.00
90.01	09001	OUTPATIENT CLINICS	840,130	14,849,328	15,689,458	0.263205	0.000000	90.01
90.02	09003	OUTPATIENT SERVICES	0	7,536,345	7,536,345	0.177638	0.000000	90.02
91.00	09100	EMERGENCY	61,038,208	172,823,268	233,861,476	0.080847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,732,063	14,456,555	16,188,618	0.414056	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,152,649,899	1,505,415,766	2,658,065,665			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,152,649,899	1,505,415,766	2,658,065,665			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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	03630	ULTRASOUND	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
55.01	05501	CYBERKNIFE	0.000000			55.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
65.01	03610	SLEEP LAB	0.000000			65.01
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03020	ACUPUNCTURE	0.000000			76.00
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
90.01	09001	OUTPATIENT CLINICS	0.000000			90.01
90.02	09003	OUTPATIENT SERVICES	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
11/24/2020 4:58 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,895,586	0	9,895,586	61,891	159.89	30.00
31.00	INTENSIVE CARE UNIT	1,699,051		1,699,051	11,781	144.22	31.00
43.00	NURSERY	91,716		91,716	7,315	12.54	43.00
200.00	Total (lines 30 through 199)	11,686,353		11,686,353	80,987		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	25,649	4,101,019				30.00
31.00	INTENSIVE CARE UNIT	1,951	281,373				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	27,600	4,382,392				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 11/24/2020 4:58 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	5,807,121	233,421,745	0.024878	46,475,201	1,156,210	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	463,367	37,305,872	0.012421	0	0	52.00
53.00	05300	ANESTHESIOLOGY	150,540	99,977,259	0.001506	17,139,234	25,812	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,239,066	98,592,049	0.012568	11,415,776	143,473	54.00
54.01	03630	ULTRASOUND	265,289	42,336,559	0.006266	2,628,676	16,471	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	631,300	70,737,683	0.008925	185,028	1,651	55.00
55.01	05501	CYBERKNIFE	34,164	8,758,087	0.003901	0	0	55.01
56.00	05600	RADIOISOTOPE	240,700	27,877,568	0.008634	1,714,318	14,801	56.00
57.00	05700	CT SCAN	265,266	160,155,089	0.001656	16,304,138	27,000	57.00
58.00	05800	MRI	548,433	52,925,076	0.010362	3,422,338	35,462	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,199,170	76,443,662	0.015687	14,584,623	228,789	59.00
60.00	06000	LABORATORY	1,600,067	267,929,825	0.005972	28,448,857	169,897	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	300,511	38,392,269	0.007827	15,811,217	123,754	65.00
65.01	03610	SLEEP LAB	20,273	7,742,900	0.002618	0	0	65.01
66.00	06600	PHYSICAL THERAPY	110,884	30,087,173	0.003685	6,590,320	24,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,864	9,437,980	0.011535	3,796,487	43,792	67.00
68.00	06800	SPEECH PATHOLOGY	8,455	3,702,999	0.002283	1,723,380	3,934	68.00
69.00	06900	ELECTROCARDIOLOGY	106,468	25,599,153	0.004159	4,222,351	17,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,968	5,932,065	0.002018	2,143,418	4,325	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	647,387	105,123,606	0.006158	23,893,162	147,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	650,624	179,142,796	0.003632	52,224,611	189,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,816,204	427,086,739	0.004253	55,877,815	237,648	73.00
74.00	07400	RENAL DIALYSIS	25,780	5,182,806	0.004974	2,341,314	11,646	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	70,234	7,422,152	0.009463	160,743	1,521	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	7,694,259	102,943,560	0.074742	67,440	5,041	90.00
90.01	09001	OUTPATIENT CLINICS	102,627	15,689,458	0.006541	367,535	2,404	90.01
90.02	09003	OUTPATIENT SERVICES	22,011	7,536,345	0.002921	0	0	90.02
91.00	09100	EMERGENCY	1,918,348	233,861,476	0.008203	26,161,994	214,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	915,355	16,188,618	0.056543	936,552	52,955	92.00
200.00		Total (lines 50 through 199)	26,974,735	2,397,532,569		338,636,528	2,899,853	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/24/2020 4:58 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	587,754	0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	159,715	0			31.00	
43.00	04300	NURSERY	0	0	0	0	0			43.00	
200.00		Total (lines 30 through 199)	0	0	0	747,469	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	587,754	61,891	9.50	25,649			30.00	
31.00	03100	INTENSIVE CARE UNIT		159,715	11,781	13.56	1,951			31.00	
43.00	04300	NURSERY		0	7,315	0.00	0			43.00	
200.00		Total (lines 30 through 199)		747,469	80,987		27,600			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	243,666								30.00
31.00	03100	INTENSIVE CARE UNIT	26,456								31.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	270,122								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 4:58 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
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	03630	ULTRASOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
55.01	05501	CYBERKNIFE		0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
65.01	03610	SLEEP LAB		0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0	76.00
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
90.01	09001	OUTPATIENT CLINICS		0	0	0	0	105,412	90.01
90.02	09003	OUTPATIENT SERVICES		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	159,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	54,368	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	319,495	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 4:58 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	233,421,745	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	37,305,872	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	99,977,259	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	98,592,049	0.000000
54.01	03630	ULTRASOUND	0	0	0	42,336,559	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	70,737,683	0.000000
55.01	05501	CYBERKNIFE	0	0	0	8,758,087	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	27,877,568	0.000000
57.00	05700	CT SCAN	0	0	0	160,155,089	0.000000
58.00	05800	MRI	0	0	0	52,925,076	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	76,443,662	0.000000
60.00	06000	LABORATORY	0	0	0	267,929,825	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	38,392,269	0.000000
65.01	03610	SLEEP LAB	0	0	0	7,742,900	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	30,087,173	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,437,980	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,702,999	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,599,153	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,932,065	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,123,606	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	179,142,796	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	427,086,739	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	5,182,806	0.000000
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,422,152	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	102,943,560	0.000000
90.01	09001	OUTPATIENT CLINICS	0	105,412	105,412	15,689,458	0.006719
90.02	09003	OUTPATIENT SERVICES	0	0	0	7,536,345	0.000000
91.00	09100	EMERGENCY	0	159,715	159,715	233,861,476	0.000683
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	54,368	54,368	16,188,618	0.003358
200.00		Total (lines 50 through 199)	0	319,495	319,495	2,397,532,569	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 11/24/2020 4:58 pm	
				Title XVIII		Hospital	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	46,475,201	0	24,131,832	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	6,762	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	17,139,234	0	10,414,425	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,415,776	0	14,293,129	0	54.00
54.01	03630	ULTRASOUND	0.000000	2,628,676	0	5,534,376	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	185,028	0	30,679,139	0	55.00
55.01	05501	CYBERKNIFE	0.000000	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.000000	1,714,318	0	9,391,393	0	56.00
57.00	05700	CT SCAN	0.000000	16,304,138	0	32,814,571	0	57.00
58.00	05800	MRI	0.000000	3,422,338	0	10,230,830	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	14,584,623	0	18,097,661	0	59.00
60.00	06000	LABORATORY	0.000000	28,448,857	0	22,798,901	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	15,811,217	0	1,021,386	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	1,416,793	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	6,590,320	0	560,580	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,796,487	0	52,514	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,723,380	0	17,294	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,222,351	0	3,925,498	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,143,418	0	198,768	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	23,893,162	0	11,546,945	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	52,224,611	0	17,600,559	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	55,877,815	0	104,818,506	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,341,314	0	285,922	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	160,743	0	2,836,503	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	67,440	0	18,668,314	0	90.00
90.01	09001	OUTPATIENT CLINICS	0.006719	367,535	2,469	2,029,872	13,639	90.01
90.02	09003	OUTPATIENT SERVICES	0.000000	0	0	113,763	0	90.02
91.00	09100	EMERGENCY	0.000683	26,161,994	17,869	32,264,784	22,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.003358	936,552	3,145	4,493,587	15,089	92.00
200.00		Total (lines 50 through 199)		338,636,528	23,483	380,244,607	50,765	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/24/2020 4:58 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	0.160790	24,131,832	1	413	3,880,157	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205692	6,762	0	0	1,391	52.00
53.00	05300	ANESTHESIOLOGY	0.011029	10,414,425	0	0	114,861	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093713	14,293,129	0	53	1,339,452	54.00
54.01	03630	ULTRASOUND	0.069637	5,534,376	0	0	385,397	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.077431	30,679,139	0	0	2,375,516	55.00
55.01	05501	CYBERKNIFE	0.268853	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.149276	9,391,393	27	11,674	1,401,910	56.00
57.00	05700	CT SCAN	0.019817	32,814,571	12	5,340	650,286	57.00
58.00	05800	MRI	0.051387	10,230,830	5	2,243	525,732	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099596	18,097,661	3	1,488	1,802,455	59.00
60.00	06000	LABORATORY	0.048085	22,798,901	0	0	1,096,285	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.119378	1,021,386	0	0	121,931	65.00
65.01	03610	SLEEP LAB	0.101832	1,416,793	0	0	144,275	65.01
66.00	06600	PHYSICAL THERAPY	0.178784	560,580	0	0	100,223	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176617	52,514	0	0	9,275	67.00
68.00	06800	SPEECH PATHOLOGY	0.151316	17,294	0	0	2,617	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065691	3,925,498	1	608	257,870	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.097012	198,768	0	0	19,283	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433765	11,546,945	248	0	5,008,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255423	17,600,559	0	0	4,495,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142526	104,818,506	874	380,647	14,939,362	73.00
74.00	07400	RENAL DIALYSIS	0.241856	285,922	0	0	69,152	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.123735	2,836,503	0	0	350,975	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	0.494176	18,668,314	28	13,859	9,225,433	90.00
90.01	09001	OUTPATIENT CLINICS	0.263205	2,029,872	0	264	534,272	90.01
90.02	09003	OUTPATIENT SERVICES	0.177638	113,763	0	2	20,209	90.02
91.00	09100	EMERGENCY	0.080847	32,264,784	0	332	2,608,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.414056	4,493,587	0	0	1,860,597	92.00
200.00		Subtotal (see instructions)		380,244,607	1,199	416,923	53,341,676	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		380,244,607	1,199	416,923	53,341,676	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 11/24/2020 4:58 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	66		50.00
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	5		54.00
54.01	03630	ULTRASOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	CYBERKNIFE	0	0		55.01
56.00	05600	RADIOISOTOPE	4	1,743		56.00
57.00	05700	CT SCAN	0	106		57.00
58.00	05800	MRI	0	115		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	148		59.00
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
65.01	03610	SLEEP LAB	0	0		65.01
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	40		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	108	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125	54,252		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
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	14	6,849		90.00
90.01	09001	OUTPATIENT CLINICS	0	69		90.01
90.02	09003	OUTPATIENT SERVICES	0	0		90.02
91.00	09100	EMERGENCY	0	27		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	251	63,420		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	251	63,420		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/24/2020 4:58 pm	
					Title XIX		Hospital		Cost	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	587,754	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	159,715	0			31.00
43.00	04300	NURSERY	0	0	0	0	0			43.00
200.00		Total (lines 30 through 199)	0	0	0	747,469	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	587,754	61,891	9.50	1,990			30.00
31.00	03100	INTENSIVE CARE UNIT		159,715	11,781	13.56	366			31.00
43.00	04300	NURSERY		0	7,315	0.00	791			43.00
200.00		Total (lines 30 through 199)		747,469	80,987		3,147			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	18,905							30.00
31.00	03100	INTENSIVE CARE UNIT	4,963							31.00
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	23,868							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 4:58 pm	
				Title XIX		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
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	03630	ULTRASOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
55.01	05501	CYBERKNIFE		0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
65.01	03610	SLEEP LAB		0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0	76.00
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
90.01	09001	OUTPATIENT CLINICS		0	0	0	0	105,412	90.01
90.02	09003	OUTPATIENT SERVICES		0	0	0	0	0	90.02
91.00	09100	EMERGENCY		0	0	0	0	159,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	54,368	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	319,495	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0200		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/24/2020 4:58 pm	
			Title XIX		Hospital		Cost	
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	233,421,745	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	37,305,872	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	99,977,259	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	98,592,049	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	42,336,559	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	70,737,683	0.000000	55.00
55.01	05501	CYBERKNIFE	0	0	0	8,758,087	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	27,877,568	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	160,155,089	0.000000	57.00
58.00	05800	MRI	0	0	0	52,925,076	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	76,443,662	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	267,929,825	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	38,392,269	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	7,742,900	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	30,087,173	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,437,980	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,702,999	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,599,153	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,932,065	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,123,606	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	179,142,796	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	427,086,739	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,182,806	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,422,152	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	102,943,560	0.000000	90.00
90.01	09001	OUTPATIENT CLINICS	0	105,412	105,412	15,689,458	0.006719	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	7,536,345	0.000000	90.02
91.00	09100	EMERGENCY	0	159,715	159,715	233,861,476	0.000683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	54,368	54,368	16,188,618	0.003358	92.00
200.00		Total (lines 50 through 199)	0	319,495	319,495	2,397,532,569		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
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	03630	ULTRASOUND	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	CYBERKNIFE	0.000000	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
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
90.01	09001	OUTPATIENT CLINICS	0.006719	0	0	0	0	90.01
90.02	09003	OUTPATIENT SERVICES	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000683	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.003358	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 4:58 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)		61,891	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		61,891	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)		56,166	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)		25,649	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)		72,463,638	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)		72,463,638	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)		72,463,638	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)		1,170.83	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		30,030,619	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)		30,030,619	41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 4:58 pm	
				Title XVIII		Hospital	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	18,987,575	11,781	1,611.71	1,951	3,144,446	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)					51,873,272	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					85,048,337	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)					4,652,514	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,923,336	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					7,575,850	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					77,472,487	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)					5,725	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,170.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,703,002	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0200

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

Worksheet D-1

Date/Time Prepared:
11/24/2020 4:58 pm

		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	9,895,586	72,463,638	0.136559	6,703,002	915,355	90.00
91.00 Nursing School cost	0	72,463,638	0.000000	6,703,002	0	91.00
92.00 Allied health cost	587,754	72,463,638	0.008111	6,703,002	54,368	92.00
93.00 All other Medical Education	0	72,463,638	0.000000	6,703,002	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/24/2020 4:58 pm	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		61,891	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		61,891	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)		56,166	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,990	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)		7,315	15.00	
16.00	Nursery days (title V or XIX only)		791	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)		72,463,638	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)		72,463,638	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)		72,463,638	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)		1,170.83	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,329,952	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,329,952	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0200

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

Worksheet D-1

Date/Time Prepared:
11/24/2020 4:58 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,168,668	7,315	706.58	791	558,905	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	18,987,575	11,781	1,611.71	366	589,886	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)						3,478,743 49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						5,725 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,170.83 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						6,703.002 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0200

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

Worksheet D-1

Date/Time Prepared:
11/24/2020 4:58 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	9,895,586	72,463,638	0.136559	6,703,002	915,355	90.00
91.00	Nursing School cost	0	72,463,638	0.000000	6,703,002	0	91.00
92.00	Allied health cost	587,754	72,463,638	0.008111	6,703,002	54,368	92.00
93.00	All other Medical Education	0	72,463,638	0.000000	6,703,002	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 4:58 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		71,691,024	30.00
31.00	03100	INTENSIVE CARE UNIT		19,497,446	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.160790	46,475,201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205692	0	52.00
53.00	05300	ANESTHESIOLOGY	0.011029	17,139,234	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093713	11,415,776	54.00
54.01	03630	ULTRASOUND	0.069637	2,628,676	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.077431	185,028	55.00
55.01	05501	CYBERKNIFE	0.268853	0	55.01
56.00	05600	RADIOISOTOPE	0.149276	1,714,318	56.00
57.00	05700	CT SCAN	0.019817	16,304,138	57.00
58.00	05800	MRI	0.051387	3,422,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099596	14,584,623	59.00
60.00	06000	LABORATORY	0.048085	28,448,857	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.119378	15,811,217	65.00
65.01	03610	SLEEP LAB	0.101832	0	65.01
66.00	06600	PHYSICAL THERAPY	0.178784	6,590,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176617	3,796,487	67.00
68.00	06800	SPEECH PATHOLOGY	0.151316	1,723,380	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065691	4,222,351	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.097012	2,143,418	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433765	23,893,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255423	52,224,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142526	55,877,815	73.00
74.00	07400	RENAL DIALYSIS	0.241856	2,341,314	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.123735	160,743	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	0.494176	67,440	90.00
90.01	09001	OUTPATIENT CLINICS	0.263205	367,535	90.01
90.02	09003	OUTPATIENT SERVICES	0.177638	0	90.02
91.00	09100	EMERGENCY	0.080847	26,161,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.414056	936,552	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		338,636,528	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)		338,636,528	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/24/2020 4:58 pm	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160790	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.205692	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.011029	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093713	0	0	54.00
54.01	03630	ULTRASOUND	0.069637	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.077431	0	0	55.00
55.01	05501	CYBERKNIFE	0.268853	0	0	55.01
56.00	05600	RADIOISOTOPE	0.149276	0	0	56.00
57.00	05700	CT SCAN	0.019817	0	0	57.00
58.00	05800	MRI	0.051387	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099596	0	0	59.00
60.00	06000	LABORATORY	0.048085	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.119378	0	0	65.00
65.01	03610	SLEEP LAB	0.101832	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.178784	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.176617	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.151316	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065691	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.097012	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.433765	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255423	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142526	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.241856	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.123735	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.494176	0	0	90.00
90.01	09001	OUTPATIENT CLINICS	0.263205	0	0	90.01
90.02	09003	OUTPATIENT SERVICES	0.177638	0	0	90.02
91.00	09100	EMERGENCY	0.080847	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.414056	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/24/2020 4:58 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)	16,721,672		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	47,046,101		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)	492,189		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	1,048,236		2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		240.73	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)		1.78	30.00
31.00	Percentage of Medicaid patient days (see instructions)		11.59	31.00
32.00	Sum of lines 30 and 31		13.37	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/24/2020 4:58 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)		8,272,872,447	8,350,599,096	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		65,308,198		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)			65,308,198	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			5,441,995	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			64,801	53.00
54.00	Special add-on payments for new technologies			77,831	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).			270,122	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			23,483	58.00
59.00	Total (sum of amounts on lines 49 through 58)			71,186,430	59.00
60.00	Primary payer payments			19,368	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			71,167,062	61.00
62.00	Deductibles billed to program beneficiaries			6,107,640	62.00
63.00	Coinsurance billed to program beneficiaries			163,878	63.00
64.00	Allowable bad debts (see instructions)			326,854	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			212,455	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			283,127	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			65,107,999	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			189,118	70.93
70.94	HRR adjustment amount (see instructions)			-250,746	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/24/2020 4:58 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	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		65,046,371	71.00	
71.01	Sequestration adjustment (see instructions)		1,086,274	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		63,666,170	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)		293,927	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		1,019,298	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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/24/2020 4:58 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	16,721,672	0	16,721,672		16,721,672
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	47,046,101	0		47,046,101	47,046,101
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	492,189	0	492,189		492,189
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,048,236	0		1,048,236	1,048,236
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
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	0
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	0.0000	0.0000	0.0000	0.0000	0
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	447,585	1,839,552	2,287,137
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	65,308,198	0	17,661,446	47,646,752	65,308,198
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	65,308,198	0	17,661,446	47,646,752	65,308,198
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,441,995	0	1,478,867	3,963,128	5,441,995

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/24/2020 4:58 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	77,831	0	42,188	35,643	77,831	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	19,182,501	51,645,523	70,828,024	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	5,085,614	0	1,360,467	3,725,147	5,085,614	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	216,527	0	80,987	135,540	216,527	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	0.0275	0.0275	0.0275	0.0275		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	139,854	0	37,413	102,441	139,854	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,441,995	0	1,478,867	3,963,128	5,441,995	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/24/2020 4:58 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	16,721,672	16,721,672		16,721,672	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	47,046,101		47,046,101	47,046,101	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	492,189	492,189		492,189	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,048,236		1,048,236	1,048,236	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	65,308,198	17,213,861	48,094,337	65,308,198	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	65,308,198	17,213,861	48,094,337	65,308,198	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,441,995	1,478,867	3,963,128	5,441,995	16.00
17.00	Special add-on payments for new technologies	54.00	77,831	42,188	35,643	77,831	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			18,734,916	52,093,108	70,828,024	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/24/2020 4:58 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	5,085,614	1,360,467	3,725,147	5,085,614	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	216,527	80,987	135,540	216,527	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	0.0275	0.0275	0.0275		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	139,854	37,413	102,441	139,854	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,441,995	1,478,867	3,963,128	5,441,995	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	189,118	59,683	129,435	189,118	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	-250,746	-43,585	-207,161	-250,746	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: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/24/2020 4:58 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		63,671	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		53,290,911	2.00
3.00	OPPS payments		51,792,457	3.00
4.00	Outlier payment (see instructions)		129,531	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		50,765	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		63,671	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		418,122	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)		418,122	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)		418,122	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		354,451	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)		63,671	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)		51,972,753	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		50	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		9,325,868	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)		42,710,506	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)		42,710,506	30.00
31.00	Primary payer payments		10,575	31.00
32.00	Subtotal (line 30 minus line 31)		42,699,931	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)		1,038,830	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		675,240	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		930,821	36.00
37.00	Subtotal (see instructions)		43,375,171	37.00
38.00	MSP-LCC reconciliation amount from PS&R		27	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)		43,375,144	40.00
40.01	Sequestration adjustment (see instructions)		724,365	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		42,238,748	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)		412,031	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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/24/2020 4:58 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		63,383,291		41,904,899	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		342,013		451,654	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	02/26/2020	59,134	02/26/2020	117,805	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)		-59,134		-117,805	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)		63,666,170		42,238,748	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		293,927		412,031	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		63,960,097		42,650,779	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: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/24/2020 4:58 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2020 4:58 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	3,478,743			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,478,743		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	3,478,743		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	0		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	0		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	3,478,743		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	3,478,743		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

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

Provider CCN: 14-0200

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

Worksheet G

Date/Time Prepared:
11/24/2020 4:58 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	261,369	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	51,953,935	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	11,567,683	0	0	0	7.00
8.00	Prepaid expenses	8,769,148	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)	72,552,135	0	0	0	11.00
FIXED ASSETS						
12.00	Land	32,059,107	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	468,918,122	0	0	0	15.00
16.00	Accumulated depreciation	-374,128,599	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	230,628,160	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	357,476,790	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,906,101	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	440,463	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,346,564	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	435,375,489	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	10,838,107	0	0	0	37.00
38.00	Salaries, wages, and fees payable	23,485,010	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	58,689,287	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	88,926,771	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	181,939,175	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	53,174,227	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	53,174,227	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	235,113,402	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	200,262,087	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	200,262,087	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	435,375,489	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0200

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

Worksheet G-1

Date/Time Prepared:
11/24/2020 4:58 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		288,306,116		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		35,180,042				2.00
3.00	Total (sum of line 1 and line 2)		323,486,158		0		3.00
4.00	TEMP RESTRICTED NET ASSETS	1,511,179		0		0	4.00
5.00	PERM RESTRICTED NET ASSETS	489,515		0		0	5.00
6.00	ROUNDING	1		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)		2,000,695		0		10.00
11.00	Subtotal (line 3 plus line 10)		325,486,853		0		11.00
12.00	TRANSFERS TO AFFILIATES	125,224,766		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)		125,224,766		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		200,262,087		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	TEMP RESTRICTED NET ASSETS		0				4.00
5.00	PERM RESTRICTED NET ASSETS		0				5.00
6.00	ROUNDING		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	TRANSFERS TO AFFILIATES		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: 14-0200

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2020 4:58 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	186,044,095		186,044,095	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)	186,044,095		186,044,095	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	50,159,346		50,159,346	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)	50,159,346		50,159,346	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	236,203,441		236,203,441	17.00
18.00	Ancillary services	892,116,804		892,116,804	18.00
19.00	Outpatient services	0	1,505,415,765	1,505,415,765	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	NURSERY	24,329,655	0	24,329,655	27.00
27.01	PROFESSIONAL FEES	3,210,783	17,551,808	20,762,591	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,155,860,683	1,522,967,573	2,678,828,256	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		471,112,931		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		471,112,931		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0200

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

Worksheet G-3

Date/Time Prepared:
11/24/2020 4:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,678,828,256	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,217,057,455	2.00
3.00	Net patient revenues (line 1 minus line 2)	461,770,801	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	471,112,931	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,342,130	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	171,313	6.00
7.00	Income from investments	241,555	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	8,814	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	2,036,406	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	REFERENCE LAB	5,562,709	24.00
24.01	PENSION BENEFIT COST	0	24.01
24.02	RENTAL INCOME	2,126,061	24.02
24.03	IHP DISTRIBUTIONS	669,891	24.03
24.04	OTHER NON OPERATING INCOME	0	24.04
24.05	GRANTS	87,690	24.05
24.06	SCHOOL NURSES	0	24.06
24.07	UNREALIZED	28,105	24.07
24.08	GAIN ON SALE OF ASSETS	-1,894	24.08
24.09	OTHER REVENUE	2,281,920	24.09
24.10	INTERCO REV	3,058,300	24.10
24.11	INVESTMENTS INCOME FROM AFFILIATES	2,088,565	24.11
24.12	RESEARCH	41,068	24.12
24.13	OCCUPATIONAL HEALTH	671,651	24.13
24.14	OTHER COMMUNITY REV	1,367,830	24.14
24.15	PENSION BENEFIT GAIN	1,759,720	24.15
24.50	COVID-19 PHE Funding	22,322,464	24.50
25.00	Total other income (sum of lines 6-24)	44,522,168	25.00
26.00	Total (line 5 plus line 25)	35,180,038	26.00
27.00	ROUNDING	-4	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-4	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	35,180,042	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0200	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/24/2020 4:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		5,085,614	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		216,527	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)		190.89	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)		1.78	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		11.59	8.00
9.00	Sum of lines 7 and 8		13.37	9.00
10.00	Allowable disproportionate share percentage (see instructions)		2.75	10.00
11.00	Disproportionate share adjustment (see instructions)		139,854	11.00
12.00	Total prospective capital payments (see instructions)		5,441,995	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