

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: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/28/2020 12:16 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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 PRESENCE SAINT JOSEPH HOSP-CHICAGO (14-0224) 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) FLAVIO MARIN
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	820,473	-90,661	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	21,134	-282		0	7.00
200.00	Total	0	841,607	-90,943	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: 14-0224		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 12:16 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2900 NORTH LAKE SHORE DRIVE			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60657		County: COOK 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		PRESENCE SAINT JOSEPH HOSP-CHICAGO	140224	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		SKILLED CARE	145568	16974		01/28/1987	N	P N	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)					1			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N		23.00		
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
			1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	3,830	0	331	5,663	180	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0224		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 12:16 pm		
				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	45.00
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	46.00
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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
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.						Y	Y		56.00
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			57.00
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			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

	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)					Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

	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	
65.01			0.00	0.00	0.000000	65.01	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	39.61	0.000000	66.00	
		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	
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)	FAMILY MEDICINE	1350	0.00	17.49	0.000000	
67.01		INTERNAL MEDICINE		0.00	59.06	0.000000	
					1.00	2.00	3.00
<u>Inpatient Psychiatric Facility PPS</u>							
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
<u>Inpatient Rehabilitation Facility PPS</u>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0224		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 12:16 pm	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N					112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N					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.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		6,243,654118.01	
						1.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y				5.06	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0224		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 12:16 pm	
		1.00		2.00			
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		14H082		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: PRESENCE CARE TRANSFORMATION CORP	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 200 S. WACKER DRIVE	PO Box:				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606		143.00	
		1.00		2.00			
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		2.00			
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	
		1.00		2.00		3.00	
		Title XIX		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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
		1.00		2.00		3.00	
		Title XIX		4.00			
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	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
		1.00		2.00		3.00	
		Title XIX		4.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/28/2020 12:16 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/28/2020 12:16 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	Y		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 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/13/2020	Y
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: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/28/2020 12:16 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRSENCE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718	PATRICK.GILLILAND@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/28/2020 12:16 pm

		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.	REGIONAL DIRECTOR OF REIMBURSEMENT	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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 12:16 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	247	83,717	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)		247	83,717	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,954	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)		266	90,671	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	44.00	26	9,516		0	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)		292			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)		1	366			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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 12:16 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)	10,743	637	39,128			1.00
2.00	HMO and other (see instructions)	4,392	8,979				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)	10,743	637	39,128			7.00
8.00	INTENSIVE CARE UNIT	1,313	86	2,584			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		53	2,176			13.00
14.00	Total (see instructions)	12,056	776	43,888	115.70	775.69	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	3,738	0	5,389	0.00	25.56	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)			208			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)				115.70	801.25	27.00
28.00	Observation Bed Days		255	1,961			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	249	484			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			1			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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/28/2020 12:16 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	2,306	421	9,303	1.00
2.00 HMO and other (see instructions)			824	1,507		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	2,306	421	9,303	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/28/2020 12:16 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	63,377,060	-1,930,128	61,446,932	1,666,597.68	36.87	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		765,031	0	765,031	11,004.80	69.52	4.01
5.00	Physician and Non Physician-Part B		429,311	0	429,311	2,697.52	159.15	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	8,263,145	8,263,145	280,010.00	29.51	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,852,903	0	1,852,903	53,167.68	34.85	9.00
10.00	Excluded area salaries (see instructions)		3,366,989	99,992	3,466,981	81,028.12	42.79	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,711,889	0	4,711,889	98,259.58	47.95	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		9,844,490	0	9,844,490	192,651.00	51.10	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,379,083	0	11,379,083			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,251,926	0	1,251,926			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		126,703	0	126,703			22.01
23.00	Physician Part B		32,487	0	32,487			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		1,863,938	0	1,863,938			25.00
25.50	Home office wage-related (core)		1,682,692	0	1,682,692			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
11/28/2020 12:16 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	-342,807	393,192	50,385	551.03	91.44	26.00
27.00	Administrative & General	5.00	4,145,881	0	4,145,881	133,582.78	31.04	27.00
28.00	Administrative & General under contract (see inst.)		492,035	0	492,035	3,406.00	144.46	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	54,283	0	54,283	3,021.75	17.96	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		2,511,183	0	2,511,183	102,947.00	24.39	33.00
34.00	Dietary	10.00	67,526	-42,781	24,745	71.77	344.78	34.00
35.00	Dietary under contract (see instructions)		3,148,312	-1,994,619	1,153,693	40,375.00	28.57	35.00
36.00	Cafeteria	11.00	0	42,781	42,781	124.09	344.76	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,548,976	-199,596	1,349,380	24,678.47	54.68	38.00
39.00	Central Services and Supply	14.00	252,007	-90,064	161,943	8,319.41	19.47	39.00
40.00	Pharmacy	15.00	1,796,446	-99,992	1,696,454	43,717.00	38.81	40.00
41.00	Medical Records & Medical Records Library	16.00	47,047	0	47,047	1,227.73	38.32	41.00
42.00	Social Service	17.00	13,888	-13,888	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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
11/28/2020 12:16 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)	68,334,248	-12,187,892	56,146,356	1,519,613.36	36.95	1.00
2.00	Excluded area salaries (see instructions)	5,219,892	99,992	5,319,884	134,195.80	39.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)	63,114,356	-12,287,884	50,826,472	1,385,417.56	36.69	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,556,379	0	14,556,379	290,910.58	50.04	4.00
5.00	Subtotal wage-related costs (see inst.)	13,061,775	0	13,061,775	0.00	25.70	5.00
6.00	Total (sum of lines 3 thru 5)	90,732,510	-12,287,884	78,444,626	1,676,328.14	46.80	6.00
7.00	Total overhead cost (see instructions)	13,734,777	-2,004,967	11,729,810	362,022.03	32.40	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2020 12:16 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		2,698,953	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		5,939,816	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		-847	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-10,335	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)		157,486	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,260,628	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		4,456,242	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		89,970	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		62,224	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		14,654,137	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: 14-0224

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 11/28/2020 12:16 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	4,711,889	14,654,137	1.00
2.00	Hospital	4,711,889	11,379,083	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	0	477,527	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	2,797,527	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/28/2020 12:16 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)			0.238312 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	13,567,543		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		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	106,262,567		6.00
7.00	Medicaid cost (line 1 times line 6)	25,323,645		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	11,756,102		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	11,756,102		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)	11,527,502	1,793,130	13,320,632 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,747,142	1,793,130	4,540,272 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)	2,747,142	1,793,130	4,540,272 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)	4,170,141		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	807,152		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,241,772		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,928,369		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,132,485		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,672,757		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,428,859		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0224

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

Worksheet A

Date/Time Prepared:
11/28/2020 12:16 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		5,337,501	5,337,501	-1,915,336	3,422,165	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,972,283	7,972,283	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-342,807	10,143,348	9,800,541	0	9,800,541	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	116,485	116,485	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	0	35,490	35,490	-69,141	-33,651	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	4,145,881	71,049,417	75,195,298	-2,894,069	72,301,229	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	12,076	12,076	0	12,076	6.00
7.00	00700	OPERATION OF PLANT	0	4,825,187	4,825,187	-655,701	4,169,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,283	630,001	684,284	0	684,284	8.00
9.00	00900	HOUSEKEEPING	0	3,236,200	3,236,200	-9,314	3,226,886	9.00
10.00	01000	DIETARY	67,526	4,823,810	4,891,336	-3,114,690	1,776,646	10.00
11.00	01100	CAFETERIA	0	0	0	3,095,507	3,095,507	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,548,976	13,157,366	14,706,342	-891,151	13,815,191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	252,007	645,670	897,677	-335,988	561,689	14.00
15.00	01500	PHARMACY	1,796,446	4,276,924	6,073,370	-3,963,031	2,110,339	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,047	201,125	248,172	-28,479	219,693	16.00
17.00	01700	SOCIAL SERVICE	13,888	1,953	15,841	0	15,841	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	8,844,153	8,844,153	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	12,091,740	3,022,903	15,114,643	-9,894,496	5,220,147	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	218,944	23,857	242,801	126,125	368,926	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,395,667	4,389,761	21,785,428	-643,191	21,142,237	30.00
31.00	03100	INTENSIVE CARE UNIT	2,382,119	460,991	2,843,110	-279,013	2,564,097	31.00
43.00	04300	NURSERY	1,463,773	1,691,917	3,155,690	470,147	3,625,837	43.00
44.00	04400	SKILLED NURSING FACILITY	1,852,903	307,940	2,160,843	-78,437	2,082,406	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,201,068	12,400,517	17,601,585	-10,231,067	7,370,518	50.00
51.00	05100	RECOVERY ROOM	623,954	46,970	670,924	-11,366	659,558	51.00
53.00	05300	ANESTHESIOLOGY	104,526	1,411,529	1,516,055	-373,186	1,142,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,971,162	1,286,151	3,257,313	-677,274	2,580,039	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,055,542	787,587	1,843,129	-180,400	1,662,729	55.00
57.00	05700	CT SCAN	356,052	118,340	474,392	-90,546	383,846	57.00
58.00	05800	MRI	272,973	221,031	494,004	-197,058	296,946	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,057,810	1,326,132	2,383,942	-1,081,392	1,302,550	59.00
60.00	06000	LABORATORY	0	6,257,304	6,257,304	-84,201	6,173,103	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	411,354	411,354	-411,354	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,190,719	492,544	1,683,263	-131,681	1,551,582	65.00
66.00	06600	PHYSICAL THERAPY	1,784,032	155,029	1,939,061	-8,963	1,930,098	66.00
69.00	06900	ELECTROCARDIOLOGY	304,076	466,043	770,119	-197,262	572,857	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,817	13,388	70,205	-4,094	66,111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,253,052	8,253,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,647,711	4,647,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,954,553	5,954,553	73.00
74.00	07400	RENAL DIALYSIS	0	341,150	341,150	0	341,150	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	84,495	9,295	93,790	-2,608	91,182	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	569,818	96,166	665,984	-52,981	613,003	90.00
91.00	09100	EMERGENCY	2,284,067	1,251,126	3,535,193	-355,923	3,179,270	91.00
91.01	09101	PARTIAL HOSPITALIZATION	323,511	23,637	347,148	0	347,148	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,229,015	155,388,730	215,617,745	616,623	216,234,368	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	3,148,045	2,537,856	5,685,901	-616,623	5,069,278	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	63,377,060	157,926,586	221,303,646	0	221,303,646	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0224

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

Worksheet A

Date/Time Prepared:
11/28/2020 12:16 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	-249,598	3,172,567	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,739,375	16,711,658	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	138,954	9,939,495	4.00
5.01	00540	NONPATIENT TELEPHONES	0	116,485	5.01
5.02	00550	DATA PROCESSING	11,310,026	11,310,026	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	-33,651	5.03
5.04	00570	ADMITTING	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	7,117,247	7,117,247	5.05
5.06	00591	ADMINISTRATION & GENERAL	-26,542,670	45,758,559	5.06
6.00	00600	MAINTENANCE & REPAIRS	1,229,028	1,241,104	6.00
7.00	00700	OPERATION OF PLANT	0	4,169,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	684,284	8.00
9.00	00900	HOUSEKEEPING	0	3,226,886	9.00
10.00	01000	DIETARY	-5,646	1,771,000	10.00
11.00	01100	CAFETERIA	-746,596	2,348,911	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-1,416,122	12,399,069	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	561,689	14.00
15.00	01500	PHARMACY	158,644	2,268,983	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,458	265,151	16.00
17.00	01700	SOCIAL SERVICE	0	15,841	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	8,844,153	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-93,826	5,126,321	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	368,926	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,020,627	19,121,610	30.00
31.00	03100	INTENSIVE CARE UNIT	661,035	3,225,132	31.00
43.00	04300	NURSERY	-1,464,537	2,161,300	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,082,406	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-247,400	7,123,118	50.00
51.00	05100	RECOVERY ROOM	0	659,558	51.00
53.00	05300	ANESTHESIOLOGY	-1,021,043	121,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-327,810	2,252,229	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-190,997	1,471,732	55.00
57.00	05700	CT SCAN	0	383,846	57.00
58.00	05800	MRI	0	296,946	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,302,550	59.00
60.00	06000	LABORATORY	79,621	6,252,724	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,551,582	65.00
66.00	06600	PHYSICAL THERAPY	0	1,930,098	66.00
69.00	06900	ELECTROCARDIOLOGY	-267,030	305,827	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	66,111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,253,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,647,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,954,553	73.00
74.00	07400	RENAL DIALYSIS	0	341,150	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	91,182	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	-2,535	610,468	90.00
91.00	09100	EMERGENCY	-639,430	2,539,840	91.00
91.01	09101	PARTIAL HOSPITALIZATION	-22,344	324,804	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,778,823	210,455,545	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	-1,816,715	3,252,563	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,595,538	213,708,108	200.00

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/28/2020 12:16 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,954,553		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	5,954,553		
	B - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,647,711		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
	TOTALS		0	4,647,711		
	C - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,253,052		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

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/28/2020 12:16 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	8,253,052		
	D - NURSEY					
1.00	NURSERY	43.00	519,821	58,053		1.00
	TOTALS		519,821	58,053		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	42,781	3,052,726		1.00
	TOTALS		42,781	3,052,726		
	F - PHYSICIAN DEPR CHAIRMAN					
1.00	ADULTS & PEDIATRICS	30.00	982,786	57,351		1.00
	TOTALS		982,786	57,351		
	G - SALARY PTO ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	393,192	0		1.00
	TOTALS		393,192	0		
	H - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,972,283		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	7,972,283		
	I - PHONES					
1.00	NONPATIENT TELEPHONES	5.01	0	116,485		1.00
	TOTALS		0	116,485		
	J - PHARMACY RESIDENCY COSTS					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	99,992	26,133		1.00
	TOTALS		99,992	26,133		
	K - CONTRACTED LABOR IN SALARY EXPENSE					
1.00	NURSING ADMINISTRATION	13.00	0	199,596		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	90,064		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	554,881		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	426,071		4.00
5.00	OPERATING ROOM	50.00	0	432,757		5.00
6.00	RECOVERY ROOM	51.00	0	148,528		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	12,625		7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	76,823		8.00
9.00	RESPIRATORY THERAPY	65.00	0	176,921		9.00
10.00	EMERGENCY	91.00	0	140,320		10.00
11.00	PARTIAL HOSPITALIZATION	91.01	0	50,846		11.00
12.00	SOCIAL SERVICE	17.00	0	13,888		12.00
	TOTALS		0	2,323,320		
	L - INTERNS AND RESIDENTS SALARY					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	8,263,145	581,008		1.00
	TOTALS		8,263,145	581,008		

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/28/2020 12:16 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
500.00	Grand Total: Increases		10,301,717	33,042,675		500.00

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/28/2020 12:16 pm

	Decreases						11/28/2020 12:16 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS						
1.00	PURCHASING, RECEIVING&STORES	5.03	0	1,934	0		1.00
2.00	ADMINISTRATION & GENERAL	5.06	0	8,188	0		2.00
3.00	OPERATION OF PLANT	7.00	0	8	0		3.00
4.00	HOUSEKEEPING	9.00	0	63	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	152,768	0		5.00
6.00	PHARMACY	15.00	0	3,772,879	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	15,781	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	133,264	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	25,362	0		9.00
10.00	NURSERY	43.00	0	7,446	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	5,279	0		11.00
12.00	OPERATING ROOM	50.00	0	196,854	0		12.00
13.00	RECOVERY ROOM	51.00	0	2,233	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	76,609	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	286,860	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	104,797	0		16.00
17.00	CT SCAN	57.00	0	60,676	0		17.00
18.00	MRI	58.00	0	8,969	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	28,468	0		19.00
20.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	411,354	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	2,646	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	2,727	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	169	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	71	0		24.00
25.00	CLINIC	90.00	0	19,949	0		25.00
26.00	EMERGENCY	91.00	0	84,351	0		26.00
27.00	OTHER	194.00	0	544,848	0		27.00
	TOTALS		0	5,954,553			
	B - IMPLANTS						
1.00	PURCHASING, RECEIVING&STORES	5.03	0	20,583	0		1.00
2.00	OPERATION OF PLANT	7.00	0	4	0		2.00
3.00	PHARMACY	15.00	0	44	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	563	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	26,767	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	4,234	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	0	557	0		7.00
8.00	OPERATING ROOM	50.00	0	3,992,668	0		8.00
9.00	RECOVERY ROOM	51.00	0	194	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	3,035	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,835	0		11.00
12.00	CT SCAN	57.00	0	677	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	419,576	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	17	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	153,605	0		15.00
16.00	CLINIC	90.00	0	16,543	0		16.00
17.00	EMERGENCY	91.00	0	5,386	0		17.00
18.00	OTHER	194.00	0	423	0		18.00
	TOTALS		0	4,647,711			
	C - CHARGABLE SUPPLIES						
1.00	PURCHASING, RECEIVING&STORES	5.03	0	46,624	0		1.00
2.00	ADMINISTRATION & GENERAL	5.06	0	232,884	0		2.00
3.00	OPERATION OF PLANT	7.00	0	382	0		3.00
4.00	DIETARY	10.00	0	64	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	4	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	165,989	0		6.00
7.00	PHARMACY	15.00	0	42,419	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	12,135	0		8.00
9.00	I&R SERVICES-OTHER PRGM	22.00	0	10,206	0		9.00
10.00	COSTS APPRV						
10.00	ADULTS & PEDIATRICS	30.00	0	829,900	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	199,513	0		11.00
12.00	NURSERY	43.00	0	93,127	0		12.00
13.00	SKILLED NURSING FACILITY	44.00	0	69,037	0		13.00
14.00	OPERATING ROOM	50.00	0	5,352,814	0		14.00
15.00	RECOVERY ROOM	51.00	0	3,730	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	234,532	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80,803	0		17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	43,494	0		18.00
19.00	CT SCAN	57.00	0	29,193	0		19.00
20.00	MRI	58.00	0	27,251	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	387,184	0		21.00
22.00	LABORATORY	60.00	0	1,361	0		22.00

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/28/2020 12:16 pm

		Decreases							11/28/2020 12:16 pm	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.					
	6.00	7.00	8.00	9.00	10.00					
23.00	RESPIRATORY THERAPY	65.00	0	103,661	0				23.00	
24.00	PHYSICAL THERAPY	66.00	0	5,239	0				24.00	
25.00	ELECTROCARDIOLOGY	69.00	0	26,374	0				25.00	
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,994	0				26.00	
27.00	CARDIAC REHABILITATION	76.97	0	1,100	0				27.00	
28.00	CLINIC	90.00	0	16,489	0				28.00	
29.00	EMERGENCY	91.00	0	198,828	0				29.00	
30.00	OTHER	194.00	0	35,721	0				30.00	
TOTALS			0	8,253,052						
D - NURSEY										
1.00	ADULTS & PEDIATRICS	30.00	519,821	58,053	0				1.00	
TOTALS			519,821	58,053						
E - CAFETERIA										
1.00	DIETARY	10.00	42,781	3,052,726	0				1.00	
TOTALS			42,781	3,052,726						
F - PHYSICIAN DEPR CHAIRMAN										
1.00	I&R SERVICES-OTHER PRGM	22.00	982,786	57,351	0				1.00	
COSTS APPRV										
TOTALS			982,786	57,351						
G - SALARY PTO ACCRUAL										
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393,192	0				1.00	
TOTALS			0	393,192						
H - EQUIP DEPRECIATION										
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,915,336	9				1.00	
2.00	ADMINISTRATION & GENERAL	5.06	0	2,536,512	0				2.00	
3.00	OPERATION OF PLANT	7.00	0	655,307	0				3.00	
4.00	HOUSEKEEPING	9.00	0	9,251	0				4.00	
5.00	DIETARY	10.00	0	19,119	0				5.00	
6.00	NURSING ADMINISTRATION	13.00	0	891,147	0				6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	17,231	0				7.00	
8.00	PHARMACY	15.00	0	21,564	0				8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	115,523	0				9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	49,904	0				10.00	
11.00	NURSERY	43.00	0	7,154	0				11.00	
12.00	SKILLED NURSING FACILITY	44.00	0	3,564	0				12.00	
13.00	OPERATING ROOM	50.00	0	688,731	0				13.00	
14.00	RECOVERY ROOM	51.00	0	5,209	0				14.00	
15.00	ANESTHESIOLOGY	53.00	0	59,010	0				15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	306,776	0				16.00	
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	32,109	0				17.00	
18.00	MRI	58.00	0	160,838	0				18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	246,164	0				19.00	
20.00	LABORATORY	60.00	0	82,840	0				20.00	
21.00	RESPIRATORY THERAPY	65.00	0	25,357	0				21.00	
22.00	PHYSICAL THERAPY	66.00	0	3,724	0				22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	14,556	0				23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	931	0				24.00	
25.00	CARDIAC REHABILITATION	76.97	0	1,437	0				25.00	
26.00	EMERGENCY	91.00	0	67,358	0				26.00	
27.00	OTHER	194.00	0	35,631	0				27.00	
TOTALS			0	7,972,283						
I - PHONES										
1.00	ADMINISTRATION & GENERAL	5.06	0	116,485	0				1.00	
TOTALS			0	116,485						
J - PHARMACY RESIDENCY COSTS										
1.00	PHARMACY	15.00	99,992	26,133	0				1.00	
TOTALS			99,992	26,133						
K - CONTRACTED LABOR IN SALARY EXPENSE										
1.00	NURSING ADMINISTRATION	13.00	199,596	0	0				1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	90,064	0	0				2.00	
3.00	ADULTS & PEDIATRICS	30.00	554,881	0	0				3.00	
4.00	INTENSIVE CARE UNIT	31.00	426,071	0	0				4.00	
5.00	OPERATING ROOM	50.00	432,757	0	0				5.00	
6.00	RECOVERY ROOM	51.00	148,528	0	0				6.00	
7.00	RADIOLOGY-THERAPEUTIC	55.00	12,625	0	0				7.00	
8.00	CARDIAC CATHETERIZATION	59.00	76,823	0	0				8.00	
9.00	RESPIRATORY THERAPY	65.00	176,921	0	0				9.00	
10.00	EMERGENCY	91.00	140,320	0	0				10.00	
11.00	PARTIAL HOSPITALIZATION	91.01	50,846	0	0				11.00	
12.00	SOCIAL SERVICE	17.00	13,888	0	0				12.00	
TOTALS			2,323,320	0						

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/28/2020 12:16 pm

	Decreases				wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	L - INTERNS AND RESIDENTS SALARY						
1.00	I&R SERVICES-OTHER PRGM	22.00	8,263,145	581,008	0	1.00	
	COSTS APPRV						
	TOTALS		8,263,145	581,008			
500.00	Grand Total: Decreases		12,231,845	31,112,547		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/28/2020 12:16 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	26,070,000	0	0	0	0	1.00	
2.00	Land Improvements	462,328	0	0	0	0	2.00	
3.00	Buildings and Fixtures	71,623,398	2,086,262	0	2,086,262	0	3.00	
4.00	Building Improvements	0	631,527	0	631,527	0	4.00	
5.00	Fixed Equipment	12,465,677	0	0	0	4,804,726	5.00	
6.00	Movable Equipment	6,147,590	9,119,297	0	9,119,297	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	116,768,993	11,837,086	0	11,837,086	4,804,726	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	116,768,993	11,837,086	0	11,837,086	4,804,726	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	26,070,000	0				1.00	
2.00	Land Improvements	462,328	0				2.00	
3.00	Buildings and Fixtures	73,709,660	0				3.00	
4.00	Building Improvements	631,527	0				4.00	
5.00	Fixed Equipment	7,660,951	0				5.00	
6.00	Movable Equipment	15,266,887	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	123,801,353	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	123,801,353	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/28/2020 12:16 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	5,337,501	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,337,501	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	5,337,501				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,337,501				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/28/2020 12:16 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	110,621,403	0	110,621,403	0.947353	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,147,590	0	6,147,590	0.052647	0	2.00
3.00	Total (sum of lines 1-2)	116,768,993	0	116,768,993	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	4,549,848	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	16,711,658	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	21,261,506	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	-1,377,281	0	0	0	3,172,567	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	16,711,658	2.00
3.00	Total (sum of lines 1-2)	-1,377,281	0	0	0	19,884,225	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0224

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

Worksheet A-8

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-4,099,088	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,422,957			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	4,034,853			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-746,596	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	A	1,127,683	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	8,739,375	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0224

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

Worksheet A-8

Date/Time Prepared:
11/28/2020 12:16 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	
34.00	MISC REVENUE	B	-16,200	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
38.00	MISC INCOME	A	-2,535	CLINIC	90.00	0	38.00
39.00	MOONLIGHTERS	A	-77,880	I&R SERVICES-OTHER PRGM	22.00	0	39.00
				COSTS APPRV			
40.00	HOCR INTEREST INCOME	B	-5,182,088	ADMINISTRATION & GENERAL	5.06	0	40.00
42.00	PHYS FEES	A	-1,816,715	OTHER	194.00	0	42.00
43.02	MISC INCOME	B	-5,646	DIETARY	10.00	0	43.02
43.03	MISC INCOME	B	-1,127,777	ADMINISTRATION & GENERAL	5.06	0	43.03
43.04	MISC INCOME		0		0.00	0	43.04
43.05	MISC INCOME	B	-15,946	I&R SERVICES-OTHER PRGM	22.00	0	43.05
				COSTS APPRV			
43.10	MISC INCOME	B	-17,700	PHARMACY	15.00	0	43.10
44.00	MISC INCOME	B	-1,501,551	NURSING ADMINISTRATION	13.00	0	44.00
45.00	MISC INCOME		0		0.00	0	45.00
46.00	MISC INCOME		0		0.00	0	46.00
47.00	MISC INCOME	B	-1,935	LABORATORY	60.00	0	47.00
48.00	BENEFITS ON PART B DOCS	A	-462,835	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,595,538				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: 14-0224 Period: From 07/01/2019 To 06/30/2020 Worksheet A-8-1 Date/Time Prepared: 11/28/2020 12:16 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	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	2,721,807	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	601,789	0	2.00
3.00	5.02	DATA PROCESSING	IT	11,310,026	0	3.00
3.01	5.05	CASHIERING/ACCTS RECEIVABLE	BUSINESS OFFICE	7,117,247	0	3.01
3.02	5.06	ADMINISTRATION & GENERAL	ADMIN AND GENERAL	24,850,962	44,902,828	3.02
3.03	6.00	MAINTENANCE & REPAIRS	BIO MED	1,229,028	0	3.03
3.04	13.00	NURSING ADMINISTRATION	NURSING ADMIN	85,429	0	3.04
3.05	15.00	PHARMACY	PHARMACY ADMIN	176,344	0	3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	HIMS	45,458	0	3.06
3.07	31.00	INTENSIVE CARE UNIT	ICU	661,035	0	3.07
4.00	60.00	LABORATORY	ALVERNO LAB	6,251,688	6,113,132	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			55,050,813	51,015,960	5.00

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

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

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

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

6.00	B		100.00	PRESENCE CARE	100.00	6.00
7.00	C		66.67	ALVERNO LABS	66.67	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0224

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2020 12:16 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	2,721,807	11		1.00
2.00	601,789	0		2.00
3.00	11,310,026	0		3.00
3.01	7,117,247	0		3.01
3.02	-20,051,866	0		3.02
3.03	1,229,028	0		3.03
3.04	85,429	0		3.04
3.05	176,344	0		3.05
3.06	45,458	0		3.06
3.07	661,035	0		3.07
4.00	138,556	0		4.00
5.00	4,034,853			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: 14-0224

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2020 12:16 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	30.00	ADULTS & PEDIATRICS	2,020,627	2,020,627	0	0	0	1.00
2.00	43.00	NURSERY	1,464,537	1,464,537	0	0	0	2.00
3.00	50.00	OPERATING ROOM	247,400	247,400	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,021,043	1,021,043	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	311,610	311,610	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	190,997	190,997	0	0	0	6.00
7.00	60.00	LABORATORY	57,000	57,000	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	267,030	267,030	0	0	0	8.00
9.00	91.00	EMERGENCY	639,430	639,430	0	0	0	9.00
10.00	91.01	PARTIAL HOSPITALIZATION	22,344	22,344	0	0	0	10.00
11.00	5.06	ADMINISTRATION & GENERAL	180,939	180,939	0	0	0	11.00
200.00			6,422,957	6,422,957	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	10.00
11.00	5.06	ADMINISTRATION & GENERAL	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,020,627		1.00
2.00	43.00	NURSERY	0	0	0	1,464,537		2.00
3.00	50.00	OPERATING ROOM	0	0	0	247,400		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,021,043		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	311,610		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	190,997		6.00
7.00	60.00	LABORATORY	0	0	0	57,000		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	267,030		8.00
9.00	91.00	EMERGENCY	0	0	0	639,430		9.00
10.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	22,344		10.00
11.00	5.06	ADMINISTRATION & GENERAL	0	0	0	180,939		11.00
200.00			0	0	0	6,422,957		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,172,567	3,172,567			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,711,658	16,711,658			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,939,495	0	9,939,495		4.00
5.01	00540	NONPATIENT TELEPHONES	116,485	0	0	116,485	5.01
5.02	00550	DATA PROCESSING	11,310,026	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	-33,651	0	0	1,924	5.03
5.04	00570	ADMITTING	0	0	0	3,420	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	7,117,247	776	4,086	5,343	5.05
5.06	00591	ADMINISTRATION & GENERAL	45,758,559	1,090,048	5,741,894	671,177	5.06
6.00	00600	MAINTENANCE & REPAIRS	1,241,104	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,169,486	114,866	605,062	4,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	684,284	7,044	37,103	8,788	8.00
9.00	00900	HOUSEKEEPING	3,226,886	124,411	655,339	0	9.00
10.00	01000	DIETARY	1,771,000	118,676	625,134	4,006	10.00
11.00	01100	CAFETERIA	2,348,911	0	0	6,926	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	12,399,069	12,213	64,334	218,451	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	561,689	0	0	26,217	14.00
15.00	01500	PHARMACY	2,268,983	22,528	118,665	274,639	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	265,151	47,395	249,655	7,616	16.00
17.00	01700	SOCIAL SERVICE	15,841	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	8,844,153	0	0	1,337,721	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,126,321	18,810	99,084	460,708	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	368,926	416	2,190	51,633	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,121,610	723,868	3,813,011	2,801,310	30.00
31.00	03100	INTENSIVE CARE UNIT	3,225,132	88,720	467,338	316,665	31.00
43.00	04300	NURSERY	2,161,300	21,926	115,494	321,124	43.00
44.00	04400	SKILLED NURSING FACILITY	2,082,406	94,175	496,073	299,966	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,123,118	246,823	1,300,152	771,942	50.00
51.00	05100	RECOVERY ROOM	659,558	12,840	67,636	76,967	51.00
53.00	05300	ANESTHESIOLOGY	121,826	5,449	28,702	16,922	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,252,229	130,846	689,239	319,111	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,471,732	36,088	190,093	168,838	55.00
57.00	05700	CT SCAN	383,846	9,638	50,768	57,641	57.00
58.00	05800	MRI	296,946	5,306	27,950	44,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,302,550	61,091	321,802	158,812	59.00
60.00	06000	LABORATORY	6,252,724	67,713	356,682	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,551,582	19,946	105,066	164,124	65.00
66.00	06600	PHYSICAL THERAPY	1,930,098	40,674	214,251	288,817	66.00
69.00	06900	ELECTROCARDIOLOGY	305,827	0	0	49,227	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,111	236	1,242	9,198	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,253,052	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,647,711	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,954,553	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	341,150	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	91,182	0	0	13,679	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	610,468	3,376	17,783	92,248	90.00
91.00	09100	EMERGENCY	2,539,840	0	0	347,051	91.00
91.01	09101	PARTIAL HOSPITALIZATION	324,804	0	0	44,142	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	210,455,545	3,125,898	16,465,828	9,429,858	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	3,252,563	46,669	245,830	509,637	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	213,708,108	3,172,567	16,711,658	9,939,495	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			DATA PROCESSING	PURCHASING, REC EIVING&STORES	ADMITTING	CASHIERING/ACC TS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	11,310,026					5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	-31,727				5.03
5.04	00570	ADMITTING	0	0	3,420			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	7,127,452		5.05
5.06	00591	ADMINISTRATION & GENERAL	11,310,026	0	0	0	64,586,238	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	1,241,104	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	4,894,330	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	737,646	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	4,007,277	9.00
10.00	01000	DIETARY	0	0	0	0	2,519,671	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,357,119	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	12,699,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	588,440	14.00
15.00	01500	PHARMACY	0	0	0	0	2,686,952	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	573,878	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17,444	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	10,181,874	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	5,710,587	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	423,165	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	1,021	1,326,976	27,805,965	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	134	155,362	4,257,519	31.00
43.00	04300	NURSERY	0	0	149	172,215	2,793,063	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	52	60,357	3,034,311	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	234	1,015,817	10,466,849	50.00
51.00	05100	RECOVERY ROOM	0	0	38	112,953	929,992	51.00
53.00	05300	ANESTHESIOLOGY	0	0	51	208,709	381,873	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	56	373,687	3,773,824	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	2	191,297	2,058,050	55.00
57.00	05700	CT SCAN	0	0	75	264,843	766,811	57.00
58.00	05800	MRI	0	0	23	117,754	492,171	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	106	233,132	2,077,493	59.00
60.00	06000	LABORATORY	0	0	313	658,653	7,342,283	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	18	26,544	26,562	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	79	96,979	1,939,272	65.00
66.00	06600	PHYSICAL THERAPY	0	0	74	97,243	2,574,149	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	82	212,555	569,401	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3	13,102	91,281	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	144	366,437	8,619,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	121	272,793	4,920,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	475	675,534	6,630,562	73.00
74.00	07400	RENAL DIALYSIS	0	0	13	16,369	358,173	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	6,441	111,623	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	1	35,302	763,666	90.00
91.00	09100	EMERGENCY	0	0	151	407,584	3,297,298	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	8,814	377,760	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,310,026	0	3,415	7,127,452	209,685,131	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	5	0	4,054,704	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	-31,727	0	0	-31,727	201.00
202.00		TOTAL (sum lines 118 through 201)	11,310,026	-31,727	3,420	7,127,452	213,708,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	64,586,238					5.06
6.00	00600	MAINTENANCE & REPAIRS	537,420	1,778,524				6.00
7.00	00700	OPERATION OF PLANT	2,119,333	98,135	7,111,798			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	319,414	6,018	25,469	1,088,547		8.00
9.00	00900	HOUSEKEEPING	1,735,223	106,290	449,842	0	6,298,632	9.00
10.00	01000	DIETARY	1,091,063	101,390	429,108	0	407,263	10.00
11.00	01100	CAFETERIA	1,020,675	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,498,981	10,434	44,161	0	41,913	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	254,805	0	0	568	0	14.00
15.00	01500	PHARMACY	1,163,499	19,246	81,455	4,686	77,308	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	248,500	40,491	171,369	0	162,645	16.00
17.00	01700	SOCIAL SERVICE	7,554	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	4,408,935	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,472,787	16,070	68,014	0	64,551	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	183,238	355	1,503	0	1,427	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,040,527	618,435	2,617,350	377,439	2,484,102	30.00
31.00	03100	INTENSIVE CARE UNIT	1,843,582	75,798	320,793	9,868	304,462	31.00
43.00	04300	NURSERY	1,209,447	18,732	79,278	79,334	75,242	43.00
44.00	04400	SKILLED NURSING FACILITY	1,313,911	80,458	340,517	71,417	323,182	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,532,334	210,872	892,458	223,458	847,025	50.00
51.00	05100	RECOVERY ROOM	402,703	10,970	46,427	11,421	44,064	51.00
53.00	05300	ANESTHESIOLOGY	165,358	4,655	19,702	0	18,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,634,134	111,788	473,112	112,770	449,026	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	891,173	30,831	130,485	33,238	123,842	55.00
57.00	05700	CT SCAN	332,043	8,234	34,848	0	33,074	57.00
58.00	05800	MRI	213,119	4,533	19,186	0	18,209	58.00
59.00	05900	CARDIAC CATHETERIZATION	899,592	52,193	220,893	31,545	209,648	59.00
60.00	06000	LABORATORY	3,179,341	57,850	244,836	13	232,372	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,502	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	839,740	17,041	72,120	0	68,449	65.00
66.00	06600	PHYSICAL THERAPY	1,114,653	34,749	147,068	2,865	139,581	66.00
69.00	06900	ELECTROCARDIOLOGY	246,561	0	0	11,654	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,526	201	853	703	809	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,732,456	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,130,719	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,871,153	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	155,095	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	48,335	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	330,681	2,884	12,207	9,817	11,586	90.00
91.00	09100	EMERGENCY	1,427,789	0	0	101,650	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	163,577	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,830,478	1,738,653	6,943,054	1,082,446	6,138,479	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	1,755,760	39,871	168,744	6,101	160,153	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	64,586,238	1,778,524	7,111,798	1,088,547	6,298,632	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	4,548,495					10.00
11.00	01100	CAFETERIA	0	3,377,794				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	54,890	0	18,349,576		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,513	0	625	862,951	14.00
15.00	01500	PHARMACY	0	97,285	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,731	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	623,047	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	98,534	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	17,402	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,893,511	1,072,631	0	9,537,294	0	30.00
31.00	03100	INTENSIVE CARE UNIT	126,660	94,508	0	1,397,860	0	31.00
43.00	04300	NURSERY	0	101,820	0	1,353,163	0	43.00
44.00	04400	SKILLED NURSING FACILITY	528,324	117,973	0	950,788	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	268,805	0	2,234,214	0	50.00
51.00	05100	RECOVERY ROOM	0	20,827	0	320,587	0	51.00
53.00	05300	ANESTHESIOLOGY	0	10,969	0	1,459	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	111,771	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	71,459	0	290,998	0	55.00
57.00	05700	CT SCAN	0	20,225	0	0	0	57.00
58.00	05800	MRI	0	13,885	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	49,522	0	409,773	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	59,009	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	87,241	0	52,789	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	19,855	0	5,279	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,489	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	553,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	309,864	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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	4,165	0	59,908	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	38,275	0	115,371	0	90.00
91.00	09100	EMERGENCY	0	121,999	0	1,413,835	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	14,949	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,548,495	3,216,779	0	18,143,943	862,951	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	161,015	0	205,633	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,548,495	3,377,794	0	18,349,576	862,951	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4,130,431					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,199,614				16.00
17.00	01700	SOCIAL SERVICE	0	0	24,998			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	223,046	19,920	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		26,157	1,293	0	0	31.00
43.00	04300	NURSERY	0	28,994	1,089	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	10,162	2,696	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	171,023	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	19,017	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	35,138	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,914	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	32,207	0	0	0	55.00
57.00	05700	CT SCAN	0	44,589	0	0	0	57.00
58.00	05800	MRI	0	19,825	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	39,250	0	0	0	59.00
60.00	06000	LABORATORY	0	110,891	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,469	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	16,327	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,372	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	35,786	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,206	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	61,693	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,927	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,130,431	113,733	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,756	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,084	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	5,943	0	0	0	90.00
91.00	09100	EMERGENCY	0	68,621	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,484	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		4,130,431	1,199,614	24,998	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)		4,130,431	1,199,614	24,998	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	15,213,856					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		8,430,543				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			627,090			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,455,613	6,347,966	0	78,493,799	-17,803,579	30.00
31.00	03100	INTENSIVE CARE UNIT	982,520	544,450	0	9,985,470	-1,526,970	31.00
43.00	04300	NURSERY	0	0	0	5,740,162	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	6,773,739	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,633,286	905,062	0	22,385,386	-2,538,348	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,806,008	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	637,853	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,445	169,258	0	7,204,042	-474,703	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,662,283	0	55.00
57.00	05700	CT SCAN	0	0	0	1,239,824	0	57.00
58.00	05800	MRI	0	0	0	780,928	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	3,989,909	0	59.00
60.00	06000	LABORATORY	6,166	3,417	0	11,177,169	-9,583	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	42,533	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,011,958	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,169,467	0	66.00
69.00	06900	ELECTROCARDIOLOGY	120,862	66,974	0	1,076,372	-187,836	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	140,068	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,966,869	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,407,135	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	627,090	14,372,969	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	516,024	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	225,115	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,689	5,923	0	1,307,042	-16,612	90.00
91.00	09100	EMERGENCY	699,275	387,493	0	7,517,960	-1,086,768	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	557,770	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,213,856	8,430,543	627,090	207,187,854	-23,644,399	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	6,551,981	0	194.00
194.01	07951	LAKE SHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-31,727	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,213,856	8,430,543	627,090	213,708,108	-23,644,399	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	5.05
5.06	00591	ADMINISTRATION & GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03950	OTHER ANCILLARY SERVICE COST CENTER	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
91.00	09100	EMERGENCY	91.00
91.01	09101	PARTIAL HOSPITALIZATION	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	194.00
194.01	07951	LAKESHORE GUEST UNIT	194.01
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: 14-0224

Period:
From 07/01/2019
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	776	4,086	4,862	5.05
5.06	00591	ADMINISTRATION & GENERAL	8,065	1,090,048	5,741,894	6,840,007	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	570	114,866	605,062	720,498	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105	7,044	37,103	44,252	8.00
9.00	00900	HOUSEKEEPING	105	124,411	655,339	779,855	9.00
10.00	01000	DIETARY	939	118,676	625,134	744,749	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	916	12,213	64,334	77,463	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	271,223	0	0	271,223	14.00
15.00	01500	PHARMACY	41,753	22,528	118,665	182,946	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	835	47,395	249,655	297,885	16.00
17.00	01700	SOCIAL SERVICE	122	0	0	122	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,271	18,810	99,084	121,165	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	416	2,190	2,606	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,591	723,868	3,813,011	4,548,470	30.00
31.00	03100	INTENSIVE CARE UNIT	1,317	88,720	467,338	557,375	31.00
43.00	04300	NURSERY	29	21,926	115,494	137,449	43.00
44.00	04400	SKILLED NURSING FACILITY	3,370	94,175	496,073	593,618	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	64,999	246,823	1,300,152	1,611,974	50.00
51.00	05100	RECOVERY ROOM	100	12,840	67,636	80,576	51.00
53.00	05300	ANESTHESIOLOGY	650	5,449	28,702	34,801	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	284	130,846	689,239	820,369	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,160	36,088	190,093	229,341	55.00
57.00	05700	CT SCAN	1	9,638	50,768	60,407	57.00
58.00	05800	MRI	0	5,306	27,950	33,256	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,575	61,091	321,802	386,468	59.00
60.00	06000	LABORATORY	1,986	67,713	356,682	426,381	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,162	19,946	105,066	126,174	65.00
66.00	06600	PHYSICAL THERAPY	1,854	40,674	214,251	256,779	66.00
69.00	06900	ELECTROCARDIOLOGY	397	0	0	397	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	192	236	1,242	1,670	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	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5	0	0	5	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	1,111	3,376	17,783	22,270	90.00
91.00	09100	EMERGENCY	1,798	0	0	1,798	91.00
91.01	09101	PARTIAL HOSPITALIZATION	140	0	0	140	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	425,625	3,125,898	16,465,828	20,017,351	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	5,530	46,669	245,830	298,029	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
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)	431,155	3,172,567	16,711,658	20,315,380	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, REC EIVING&STORES	ADMITTING	CASHIERING/ACC TS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0			5.03
5.04	00570	ADMITTING	0		0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	4,862	5.05
5.06	00591	ADMINISTRATION & GENERAL	0	0	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	1,101	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	101	31.00
43.00	04300	NURSERY	0	0	0	0	112	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	39	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	659	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	73	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	242	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	124	55.00
57.00	05700	CT SCAN	0	0	0	0	172	57.00
58.00	05800	MRI	0	0	0	0	76	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	151	59.00
60.00	06000	LABORATORY	0	0	0	0	427	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	17	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	63	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	63	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	138	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	438	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	11	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	4	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	23	90.00
91.00	09100	EMERGENCY	0	0	0	0	264	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	6	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	4,862	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	0	4,862	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
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To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	6,840,007					5.06
6.00	00600	MAINTENANCE & REPAIRS	56,916	56,916				6.00
7.00	00700	OPERATION OF PLANT	224,449	3,140	948,087			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,828	193	3,395	81,668		8.00
9.00	00900	HOUSEKEEPING	183,770	3,401	59,969	0	1,026,995	9.00
10.00	01000	DIETARY	115,550	3,245	57,205	0	66,404	10.00
11.00	01100	CAFETERIA	108,095	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	582,372	334	5,887	0	6,834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,985	0	0	43	0	14.00
15.00	01500	PHARMACY	123,221	616	10,859	352	12,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,317	1,296	22,846	0	26,519	16.00
17.00	01700	SOCIAL SERVICE	800	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	466,931	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	261,882	514	9,067	0	10,525	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	19,406	11	200	0	233	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,275,125	19,793	348,924	28,315	405,033	30.00
31.00	03100	INTENSIVE CARE UNIT	195,246	2,426	42,766	740	49,643	31.00
43.00	04300	NURSERY	128,087	599	10,569	5,952	12,268	43.00
44.00	04400	SKILLED NURSING FACILITY	139,150	2,575	45,395	5,358	52,695	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	479,999	6,748	118,975	16,765	138,108	50.00
51.00	05100	RECOVERY ROOM	42,649	351	6,189	857	7,185	51.00
53.00	05300	ANESTHESIOLOGY	17,512	149	2,626	0	3,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,064	3,577	63,071	8,461	73,214	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	94,380	987	17,395	2,494	20,193	55.00
57.00	05700	CT SCAN	35,165	264	4,646	0	5,393	57.00
58.00	05800	MRI	22,570	145	2,558	0	2,969	58.00
59.00	05900	CARDIAC CATHETERIZATION	95,272	1,670	29,448	2,367	34,183	59.00
60.00	06000	LABORATORY	336,710	1,851	32,640	1	37,888	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,218	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	88,933	545	9,614	0	11,161	65.00
66.00	06600	PHYSICAL THERAPY	118,048	1,112	19,606	215	22,759	66.00
69.00	06900	ELECTROCARDIOLOGY	26,112	0	0	874	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,186	6	114	53	132	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	395,288	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	225,655	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	304,071	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,425	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,119	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	35,021	92	1,627	737	1,889	90.00
91.00	09100	EMERGENCY	151,211	0	0	7,626	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	17,324	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,654,062	55,640	925,591	81,210	1,000,882	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	185,945	1,276	22,496	458	26,113	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	6,840,007	56,916	948,087	81,668	1,026,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING & STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	987,153					10.00
11.00	01100	CAFETERIA	0	108,095				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,757	0	674,647		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	592	0	23	298,866	14.00
15.00	01500	PHARMACY	0	3,113	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	87	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	19,939	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,153	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	557	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	845,003	34,329	0	350,650	0	30.00
31.00	03100	INTENSIVE CARE UNIT	27,489	3,024	0	51,394	0	31.00
43.00	04300	NURSERY	0	3,258	0	49,751	0	43.00
44.00	04400	SKILLED NURSING FACILITY	114,661	3,775	0	34,957	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,602	0	82,144	0	50.00
51.00	05100	RECOVERY ROOM	0	666	0	11,787	0	51.00
53.00	05300	ANESTHESIOLOGY	0	351	0	54	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,577	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,287	0	10,699	0	55.00
57.00	05700	CT SCAN	0	647	0	0	0	57.00
58.00	05800	MRI	0	444	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,585	0	15,066	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,888	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,792	0	1,941	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	635	0	194	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	144	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	191,550	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	107,316	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	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	133	0	2,203	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	1,225	0	4,242	0	90.00
91.00	09100	EMERGENCY	0	3,904	0	51,982	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	478	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	987,153	102,942	0	667,087	298,866	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	5,153	0	7,560	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	987,153	108,095	0	674,647	298,866	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	333,712					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	374,950				16.00
17.00	01700	SOCIAL SERVICE	0	0	922			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	69,694	735			30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,176	48			31.00
43.00	04300	NURSERY	0	9,063	40			43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,176	99			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	53,458	0			50.00
51.00	05100	RECOVERY ROOM	0	5,944	0			51.00
53.00	05300	ANESTHESIOLOGY	0	10,984	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,666	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,067	0			55.00
57.00	05700	CT SCAN	0	13,938	0			57.00
58.00	05800	MRI	0	6,197	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,269	0			59.00
60.00	06000	LABORATORY	0	34,662	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,397	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	5,104	0			65.00
66.00	06600	PHYSICAL THERAPY	0	5,118	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,186	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	689	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,284	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,356	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	333,712	35,551	0			73.00
74.00	07400	RENAL DIALYSIS	0	861	0			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	339	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,858	0			90.00
91.00	09100	EMERGENCY	0	21,449	0			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	464	0			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		333,712	374,950	922	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0			194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)		333,712	374,950	922	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	486,870					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		406,306				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23,013			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				7,927,172	0	30.00
31.00	03100	INTENSIVE CARE UNIT				938,428	0	31.00
43.00	04300	NURSERY				357,148	0	43.00
44.00	04400	SKILLED NURSING FACILITY				995,498	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				2,517,432	0	50.00
51.00	05100	RECOVERY ROOM				156,277	0	51.00
53.00	05300	ANESTHESIOLOGY				69,661	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,165,241	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				387,967	0	55.00
57.00	05700	CT SCAN				120,632	0	57.00
58.00	05800	MRI				68,215	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				578,479	0	59.00
60.00	06000	LABORATORY				870,560	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				2,632	0	63.00
65.00	06500	RESPIRATORY THERAPY				243,482	0	65.00
66.00	06600	PHYSICAL THERAPY				428,433	0	66.00
69.00	06900	ELECTROCARDIOLOGY				39,536	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				7,002	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				606,360	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				347,504	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				673,772	0	73.00
74.00	07400	RENAL DIALYSIS				17,297	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER				0	0	76.00
76.97	07697	CARDIAC REHABILITATION				7,803	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				68,984	0	90.00
91.00	09100	EMERGENCY				238,234	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION				18,412	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	18,852,161	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER				547,030	0	194.00
194.01	07951	LAKESHORE GUEST UNIT				0	0	194.01
200.00		Cross Foot Adjustments	486,870	406,306	23,013	916,189	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	486,870	406,306	23,013	20,315,380	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/28/2020 12:16 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
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	5.05
5.06	00591	ADMINISTRATION & GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03950	OTHER ANCILLARY SERVICE COST CENTER	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
91.00	09100	EMERGENCY	91.00
91.01	09101	PARTIAL HOSPITALIZATION	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	194.00
194.01	07951	LAKESHORE GUEST UNIT	194.01
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: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	511,214				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		511,214			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	61,396,547		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	1,090	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	0	0	0	18	5.03
5.04	00570	ADMITTING	0	0	0	32	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	125	125	0	50	5.05
5.06	00591	ADMINISTRATION & GENERAL	175,646	175,646	4,145,881	136	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	18,509	18,509	0	46	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	54,283	4	8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	0	6	9.00
10.00	01000	DIETARY	19,123	19,123	24,745	8	10.00
11.00	01100	CAFETERIA	0	0	42,781	12	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	1,349,380	48	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	161,943	5	14.00
15.00	01500	PHARMACY	3,630	3,630	1,696,454	20	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	47,047	38	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	15	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	8,263,145	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	2,845,809	53	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	67	67	318,936	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	116,641	116,641	17,303,751	170	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	1,956,048	39	31.00
43.00	04300	NURSERY	3,533	3,533	1,983,594	8	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	1,852,903	12	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,772	39,772	4,768,311	82	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	475,426	0	51.00
53.00	05300	ANESTHESIOLOGY	878	878	104,526	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	1,971,162	81	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	1,042,917	0	55.00
57.00	05700	CT SCAN	1,553	1,553	356,052	0	57.00
58.00	05800	MRI	855	855	272,973	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	980,987	0	59.00
60.00	06000	LABORATORY	10,911	10,911	0	58	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	1,013,798	14	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	1,784,032	28	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	304,076	16	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	56,817	13	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	0	0	6	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	84,495	3	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	544	544	569,818	42	90.00
91.00	09100	EMERGENCY	0	0	2,143,747	25	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	272,665	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	503,694	503,694	58,248,502	1,090	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	7,520	7,520	3,148,045	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,172,567	16,711,658	9,939,495	116,485	11,310,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.205947	32.690142	0.161890	106.866972	113,100.260000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING & STORES	13,250,403				5.03
5.04	00570	ADMITTING	0	429,162,882			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	770,182,916		5.05
5.06	00591	ADMINISTRATION & GENERAL	497,648	0	0	-64,586,238	149,153,597
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	1,241,104
7.00	00700	OPERATION OF PLANT	56	0	0	0	4,894,330
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	737,646
9.00	00900	HOUSEKEEPING	114	0	0	0	4,007,277
10.00	01000	DIETARY	303	0	0	0	2,519,671
11.00	01100	CAFETERIA	0	0	0	0	2,357,119
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	7,740	0	0	0	12,699,197
14.00	01400	CENTRAL SERVICES & SUPPLY	119,542	0	0	0	588,440
15.00	01500	PHARMACY	35,413	0	0	0	2,686,952
16.00	01600	MEDICAL RECORDS & LIBRARY	12,706	0	0	0	573,878
17.00	01700	SOCIAL SERVICE	550	0	0	0	17,444
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	10,181,874
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	80,159	0	0	0	5,710,587
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	423,165
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	426,936	129,177,054	143,375,671	0	27,805,965
31.00	03100	INTENSIVE CARE UNIT	61,222	16,788,614	16,788,614	0	4,257,519
43.00	04300	NURSERY	30,666	18,609,826	18,609,826	0	2,793,063
44.00	04400	SKILLED NURSING FACILITY	30,556	6,522,283	6,522,283	0	3,034,311
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,903,064	29,214,048	109,770,545	0	10,466,849
51.00	05100	RECOVERY ROOM	2,376	4,744,417	12,205,820	0	929,992
53.00	05300	ANESTHESIOLOGY	58,956	6,434,982	22,553,393	0	381,873
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,589	6,972,731	40,381,129	0	3,773,824
55.00	05500	RADIOLOGY-THERAPEUTIC	70,180	300,261	20,671,801	0	2,058,050
57.00	05700	CT SCAN	6,695	9,366,785	28,619,306	0	766,811
58.00	05800	MRI	2,454	2,852,607	12,724,656	0	492,171
59.00	05900	CARDIAC CATHETERIZATION	144,982	13,306,430	25,192,608	0	2,077,493
60.00	06000	LABORATORY	24,747	39,142,779	71,174,943	0	7,342,283
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	95	2,236,081	2,868,360	0	26,562
65.00	06500	RESPIRATORY THERAPY	17,617	9,818,346	10,479,643	0	1,939,272
66.00	06600	PHYSICAL THERAPY	2,120	9,302,189	10,508,224	0	2,574,149
69.00	06900	ELECTROCARDIOLOGY	5,155	10,240,336	22,968,941	0	569,401
70.00	07000	ELECTROENCEPHALOGRAPHY	650	404,549	1,415,768	0	91,281
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,252,374	17,982,512	39,597,650	0	8,619,633
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,063,216	29,478,354	0	4,920,625
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,359,500	72,999,105	0	6,630,562
74.00	07400	RENAL DIALYSIS	0	1,656,611	1,768,890	0	358,173
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	395	382	696,074	0	111,623
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,933	113,097	3,814,738	0	763,666
91.00	09100	EMERGENCY	82,598	18,865,729	44,044,092	0	3,297,298
91.01	09101	PARTIAL HOSPITALIZATION	78	3,708	952,482	0	377,760
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,196,669	428,479,073	770,182,916	-64,586,238	145,098,893
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	53,734	683,809	0	0	4,054,704
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	-31,727	3,420	7,127,452		64,586,238
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000008	0.009254		0.433018

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	4,862		6,840,007	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000006		0.045859	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: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	
		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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING&STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE					5.05
5.06	00591	ADMINISTRATION & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS	335,443				6.00
7.00	00700	OPERATION OF PLANT	18,509	316,934			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	925,528		8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	0	295,752	9.00
10.00	01000	DIETARY	19,123	19,123	0	19,123	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	0	1,968	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	483	0	14.00
15.00	01500	PHARMACY	3,630	3,630	3,984	3,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	0	7,637	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	0	3,031	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	67	67	0	67	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	116,641	116,641	320,914	116,641	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	8,390	14,296	31.00
43.00	04300	NURSERY	3,533	3,533	67,453	3,533	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	60,722	15,175	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,772	39,772	189,993	39,772	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	9,711	2,069	51.00
53.00	05300	ANESTHESIOLOGY	878	878	0	878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	95,882	21,084	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	28,260	5,815	55.00
57.00	05700	CT SCAN	1,553	1,553	0	1,553	57.00
58.00	05800	MRI	855	855	0	855	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	26,821	9,844	59.00
60.00	06000	LABORATORY	10,911	10,911	11	10,911	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	0	3,214	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	2,436	6,554	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	9,909	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	598	38	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	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	544	544	8,347	544	90.00
91.00	09100	EMERGENCY	0	0	86,427	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	327,923	309,414	920,341	288,232	115,993
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	7,520	7,520	5,187	7,520	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
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)	1,778,524	7,111,798	1,088,547	6,298,632	4,548,495
203.00		Unit cost multiplier (Wkst. B, Part I)	5.302016	22.439366	1.176136	21.297006	39.213530

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	56,916	948,087	81,668	1,026,995	987,153	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.169674	2.991434	0.088239	3.472487	8.510453	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: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			CAFETERIA (MEALS SERV ED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS))	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING & STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	72,983					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,186	0	528,358			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	400	0	18	12,875,689		14.00
15.00	01500	PHARMACY	2,102	0	0	0	5,950,335	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	13,462	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,129	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	376	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,176	0	274,617	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,042	0	40,250	0	0	31.00
43.00	04300	NURSERY	2,200	0	38,963	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,549	0	27,377	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,808	0	64,332	0	0	50.00
51.00	05100	RECOVERY ROOM	450	0	9,231	0	0	51.00
53.00	05300	ANESTHESIOLOGY	237	0	42	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,415	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,544	0	8,379	0	0	55.00
57.00	05700	CT SCAN	437	0	0	0	0	57.00
58.00	05800	MRI	300	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,070	0	11,799	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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,275	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,885	0	1,520	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	429	0	152	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,252,374	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,623,315	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,950,335	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	90	0	1,725	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	827	0	3,322	0	0	90.00
91.00	09100	EMERGENCY	2,636	0	40,710	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	323	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,504	0	522,437	12,875,689	5,950,335	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	3,479	0	5,921	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,377,794	0	18,349,576	862,951	4,130,431	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.281929	0.000000	34.729437	0.067022	0.694151	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		CAFETERIA (MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS))	
		11.00	12.00	13.00	14.00	15.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	108,095	0	674,647	298,866	333,712	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.481098	0.000000	1.276875	0.023212	0.056083	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: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED T IME))	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	770,182,916					16.00
17.00	01700	SOCIAL SERVICE	0	49,969				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			37,008	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	143,375,671	39,820	0	0	27,866	30.00
31.00	03100	INTENSIVE CARE UNIT	16,788,614	2,584	0	0	2,390	31.00
43.00	04300	NURSERY	18,609,826	2,176	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,522,283	5,389	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	109,770,545	0	0	0	3,973	50.00
51.00	05100	RECOVERY ROOM	12,205,820	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	22,553,393	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,381,129	0	0	0	743	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,671,801	0	0	0	0	55.00
57.00	05700	CT SCAN	28,619,306	0	0	0	0	57.00
58.00	05800	MRI	12,724,656	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,192,608	0	0	0	0	59.00
60.00	06000	LABORATORY	71,174,943	0	0	0	15	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,868,360	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	10,479,643	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,508,224	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	22,968,941	0	0	0	294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,415,768	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,597,650	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,478,354	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,999,105	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,768,890	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	696,074	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	3,814,738	0	0	0	26	90.00
91.00	09100	EMERGENCY	44,044,092	0	0	0	1,701	91.00
91.01	09101	PARTIAL HOSPITALIZATION	952,482	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	770,182,916	49,969	0	0	37,008	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKE SHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,199,614	24,998	0	0	15,213,856	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001558	0.500270	0.000000	0.000000	411.096412	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	374,950	922	0	0	486,870	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000487	0.018451	0.000000	0.000000	13.155804	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED T IME))		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING,RECEIVING&STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATION & GENERAL			5.06
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	37,008		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	27,866	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,390	0	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,973	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
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	15	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	294	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	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	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	26	0	90.00
91.00	09100	EMERGENCY	1,701	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,008	100	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))		
			22.00	23.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	8,430,543	627,090	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	227.803259	6,270.900000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	406,306	23,013	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.978869	230.130000	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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

				Title XVIII	Hospital	PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,690,220		60,690,220	0	60,690,220	30.00
31.00	03100	INTENSIVE CARE UNIT	8,458,500		8,458,500	0	8,458,500	31.00
43.00	04300	NURSERY	5,740,162		5,740,162	0	5,740,162	43.00
44.00	04400	SKILLED NURSING FACILITY	6,773,739		6,773,739	0	6,773,739	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,847,038		19,847,038	0	19,847,038	50.00
51.00	05100	RECOVERY ROOM	1,806,008		1,806,008	0	1,806,008	51.00
53.00	05300	ANESTHESIOLOGY	637,853		637,853	0	637,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,729,339		6,729,339	0	6,729,339	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,662,283		3,662,283	0	3,662,283	55.00
57.00	05700	CT SCAN	1,239,824		1,239,824	0	1,239,824	57.00
58.00	05800	MRI	780,928		780,928	0	780,928	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,989,909		3,989,909	0	3,989,909	59.00
60.00	06000	LABORATORY	11,167,586		11,167,586	0	11,167,586	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	42,533		42,533	0	42,533	63.00
65.00	06500	RESPIRATORY THERAPY	3,011,958	0	3,011,958	0	3,011,958	65.00
66.00	06600	PHYSICAL THERAPY	4,169,467	0	4,169,467	0	4,169,467	66.00
69.00	06900	ELECTROCARDIOLOGY	888,536		888,536	0	888,536	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	140,068		140,068	0	140,068	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,966,869		12,966,869	0	12,966,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,407,135		7,407,135	0	7,407,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,372,969		14,372,969	0	14,372,969	73.00
74.00	07400	RENAL DIALYSIS	516,024		516,024	0	516,024	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	225,115		225,115	0	225,115	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	1,290,430		1,290,430	0	1,290,430	90.00
91.00	09100	EMERGENCY	6,431,192		6,431,192	0	6,431,192	91.00
91.01	09101	PARTIAL HOSPITALIZATION	557,770		557,770	0	557,770	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,896,475		2,896,475	0	2,896,475	92.00
200.00		Subtotal (see instructions)	186,439,930	0	186,439,930	0	186,439,930	200.00
201.00		Less Observation Beds	2,896,475		2,896,475	0	2,896,475	201.00
202.00		Total (see instructions)	183,543,455	0	183,543,455	0	183,543,455	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	128,318,309		128,318,309		30.00
31.00	03100	INTENSIVE CARE UNIT	16,788,614		16,788,614		31.00
43.00	04300	NURSERY	18,609,826		18,609,826		43.00
44.00	04400	SKILLED NURSING FACILITY	6,522,283		6,522,283		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,214,048	80,556,497	109,770,545	0.180805	50.00
51.00	05100	RECOVERY ROOM	4,744,417	7,461,403	12,205,820	0.147963	51.00
53.00	05300	ANESTHESIOLOGY	6,434,982	16,118,411	22,553,393	0.028282	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,972,731	33,408,398	40,381,129	0.166646	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	300,261	20,371,540	20,671,801	0.177163	55.00
57.00	05700	CT SCAN	9,366,785	19,252,521	28,619,306	0.043321	57.00
58.00	05800	MRI	2,852,607	9,872,049	12,724,656	0.061371	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,306,430	11,886,178	25,192,608	0.158376	59.00
60.00	06000	LABORATORY	39,142,779	32,032,164	71,174,943	0.156903	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,236,081	632,279	2,868,360	0.014828	63.00
65.00	06500	RESPIRATORY THERAPY	9,818,346	661,297	10,479,643	0.287410	65.00
66.00	06600	PHYSICAL THERAPY	9,302,189	1,206,035	10,508,224	0.396781	66.00
69.00	06900	ELECTROCARDIOLOGY	10,240,336	12,728,605	22,968,941	0.038684	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	404,549	1,011,219	1,415,768	0.098934	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,982,512	21,615,138	39,597,650	0.327466	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,063,216	14,415,138	29,478,354	0.251274	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,359,500	13,639,605	72,999,105	0.196892	73.00
74.00	07400	RENAL DIALYSIS	1,656,611	112,279	1,768,890	0.291722	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	382	695,692	696,074	0.323407	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	113,097	3,701,641	3,814,738	0.338275	90.00
91.00	09100	EMERGENCY	18,865,729	25,178,363	44,044,092	0.146017	91.00
91.01	09101	PARTIAL HOSPITALIZATION	3,708	948,774	952,482	0.585596	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	858,745	14,198,617	15,057,362	0.192363	92.00
200.00		Subtotal (see instructions)	428,479,073	341,703,843	770,182,916		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	428,479,073	341,703,843	770,182,916		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 12:16 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
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.180805		50.00
51.00	05100	RECOVERY ROOM	0.147963		51.00
53.00	05300	ANESTHESIOLOGY	0.028282		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166646		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177163		55.00
57.00	05700	CT SCAN	0.043321		57.00
58.00	05800	MRI	0.061371		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.158376		59.00
60.00	06000	LABORATORY	0.156903		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.014828		63.00
65.00	06500	RESPIRATORY THERAPY	0.287410		65.00
66.00	06600	PHYSICAL THERAPY	0.396781		66.00
69.00	06900	ELECTROCARDIOLOGY	0.038684		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.098934		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327466		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251274		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196892		73.00
74.00	07400	RENAL DIALYSIS	0.291722		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.323407		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	0.338275		90.00
91.00	09100	EMERGENCY	0.146017		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.585596		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192363		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

Worksheet C
Part I
Date/Time Prepared:
11/28/2020 12:16 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 12:16 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	128,318,309		128,318,309			30.00
31.00	03100	INTENSIVE CARE UNIT	16,788,614		16,788,614			31.00
43.00	04300	NURSERY	18,609,826		18,609,826			43.00
44.00	04400	SKILLED NURSING FACILITY	6,522,283		6,522,283			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,214,048	80,556,497	109,770,545	0.180805	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,744,417	7,461,403	12,205,820	0.147963	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,434,982	16,118,411	22,553,393	0.028282	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,972,731	33,408,398	40,381,129	0.166646	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	300,261	20,371,540	20,671,801	0.177163	0.000000	55.00
57.00	05700	CT SCAN	9,366,785	19,252,521	28,619,306	0.043321	0.000000	57.00
58.00	05800	MRI	2,852,607	9,872,049	12,724,656	0.061371	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,306,430	11,886,178	25,192,608	0.158376	0.000000	59.00
60.00	06000	LABORATORY	39,142,779	32,032,164	71,174,943	0.156903	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,236,081	632,279	2,868,360	0.014828	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	9,818,346	661,297	10,479,643	0.287410	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,302,189	1,206,035	10,508,224	0.396781	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,240,336	12,728,605	22,968,941	0.038684	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	404,549	1,011,219	1,415,768	0.098934	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,982,512	21,615,138	39,597,650	0.327466	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,063,216	14,415,138	29,478,354	0.251274	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,359,500	13,639,605	72,999,105	0.196892	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,656,611	112,279	1,768,890	0.291722	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	382	695,692	696,074	0.323407	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	113,097	3,701,641	3,814,738	0.338275	0.000000	90.00
91.00	09100	EMERGENCY	18,865,729	25,178,363	44,044,092	0.146017	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	3,708	948,774	952,482	0.585596	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	858,745	14,198,617	15,057,362	0.192363	0.000000	92.00
200.00		Subtotal (see instructions)	428,479,073	341,703,843	770,182,916			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	428,479,073	341,703,843	770,182,916			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/28/2020 12:16 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
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03950	OTHER ANCILLARY SERVICE COST CENTER	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
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part I Date/Time Prepared: 11/28/2020 12:16 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	7,927,172	0	7,927,172	41,089	192.93	30.00	
31.00	INTENSIVE CARE UNIT	938,428		938,428	2,584	363.17	31.00	
43.00	NURSERY	357,148		357,148	2,176	164.13	43.00	
44.00	SKILLED NURSING FACILITY	995,498		995,498	5,389	184.73	44.00	
200.00	Total (lines 30 through 199)	10,218,246		10,218,246	51,238		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	10,743	2,072,647					30.00
31.00	INTENSIVE CARE UNIT	1,313	476,842					31.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	3,738	690,521					44.00
200.00	Total (lines 30 through 199)	15,794	3,240,010					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/28/2020 12:16 pm

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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,517,432	109,770,545	0.022934	8,690,723	199,313	50.00
51.00	05100 RECOVERY ROOM	156,277	12,205,820	0.012803	1,500,742	19,214	51.00
53.00	05300 ANESTHESIOLOGY	69,661	22,553,393	0.003089	1,694,752	5,235	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,165,241	40,381,129	0.028856	2,809,398	81,068	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	387,967	20,671,801	0.018768	166,735	3,129	55.00
57.00	05700 CT SCAN	120,632	28,619,306	0.004215	3,854,156	16,245	57.00
58.00	05800 MRI	68,215	12,724,656	0.005361	835,480	4,479	58.00
59.00	05900 CARDIAC CATHETERIZATION	578,479	25,192,608	0.022962	5,462,059	125,420	59.00
60.00	06000 LABORATORY	870,560	71,174,943	0.012231	13,185,310	161,270	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,632	2,868,360	0.000918	534,072	490	63.00
65.00	06500 RESPIRATORY THERAPY	243,482	10,479,643	0.023234	3,591,684	83,449	65.00
66.00	06600 PHYSICAL THERAPY	428,433	10,508,224	0.040771	1,685,412	68,716	66.00
69.00	06900 ELECTROCARDIOLOGY	39,536	22,968,941	0.001721	4,057,504	6,983	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	7,002	1,415,768	0.004946	157,268	778	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	606,360	39,597,650	0.015313	6,075,245	93,030	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	347,504	29,478,354	0.011788	6,280,299	74,032	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	673,772	72,999,105	0.009230	16,629,090	153,487	73.00
74.00	07400 RENAL DIALYSIS	17,297	1,768,890	0.009778	802,277	7,845	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	7,803	696,074	0.011210	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	68,984	3,814,738	0.018084	29,863	540	90.00
91.00	09100 EMERGENCY	238,234	44,044,092	0.005409	7,324,727	39,619	91.00
91.01	09101 PARTIAL HOSPITALIZATION	18,412	952,482	0.019331	3,708	72	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	378,329	15,057,362	0.025126	437,086	10,982	92.00
200.00	Total (lines 50 through 199)	9,012,244	599,943,884		85,807,590	1,155,396	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0224		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 11/28/2020 12:16 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	41,089	0.00	10,743		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	2,584	0.00	1,313		31.00	
43.00	04300	NURSERY			0	2,176	0.00	0		43.00	
44.00	04400	SKILLED NURSING FACILITY			0	5,389	0.00	3,738		44.00	
200.00		Total (lines 30 through 199)			0	51,238		15,794		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
43.00	04300	NURSERY		0						43.00	
44.00	04400	SKILLED NURSING FACILITY		0						44.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0224

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 12:16 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	109,770,545	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,205,820	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	22,553,393	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,381,129	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,671,801	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,619,306	0.000000	57.00
58.00	05800	MRI	0	0	0	12,724,656	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,192,608	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	71,174,943	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,868,360	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,479,643	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,508,224	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,968,941	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,415,768	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	39,597,650	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,478,354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	627,090	627,090	72,999,105	0.008590	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,768,890	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	696,074	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	3,814,738	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,044,092	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	952,482	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,057,362	0.000000	92.00
200.00		Total (lines 50 through 199)	0	627,090	627,090	599,943,884		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 14-0224 Period: From 07/01/2019 To 06/30/2020 Worksheet D Part IV Date/Time Prepared: 11/28/2020 12:16 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	8,690,723	0	13,479,734	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,500,742	0	1,059,991	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,694,752	0	2,837,775	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,809,398	0	6,717,113	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	166,735	0	6,949,712	0	55.00
57.00	05700	CT SCAN	0.000000	3,854,156	0	5,355,064	0	57.00
58.00	05800	MRI	0.000000	835,480	0	2,077,078	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,462,059	0	6,053,805	0	59.00
60.00	06000	LABORATORY	0.000000	13,185,310	0	6,270,831	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	534,072	0	175,331	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,591,684	0	194,097	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,685,412	0	104,953	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,057,504	0	3,571,627	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	157,268	0	273,928	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,075,245	0	4,119,718	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,280,299	0	3,522,237	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.008590	16,629,090	142,844	1,915,849	16,457	73.00
74.00	07400	RENAL DIALYSIS	0.000000	802,277	0	92,420	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	394,696	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	29,863	0	955,914	0	90.00
91.00	09100	EMERGENCY	0.000000	7,324,727	0	4,436,402	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	3,708	0	205,659	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	437,086	0	2,137,775	0	92.00
200.00		Total (lines 50 through 199)		85,807,590	142,844	72,901,709	16,457	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/28/2020 12:16 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	0.180805	13,479,734	0	3,306	2,437,203	50.00	
51.00	05100	RECOVERY ROOM	0.147963	1,059,991	0	0	156,839	51.00	
53.00	05300	ANESTHESIOLOGY	0.028282	2,837,775	0	0	80,258	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166646	6,717,113	0	22	1,119,380	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177163	6,949,712	0	9,810	1,231,232	55.00	
57.00	05700	CT SCAN	0.043321	5,355,064	0	11,029	231,987	57.00	
58.00	05800	MRI	0.061371	2,077,078	0	2,734	127,472	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.158376	6,053,805	0	2,499	958,777	59.00	
60.00	06000	LABORATORY	0.156903	6,270,831	0	0	983,912	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.014828	175,331	0	35	2,600	63.00	
65.00	06500	RESPIRATORY THERAPY	0.287410	194,097	0	0	55,785	65.00	
66.00	06600	PHYSICAL THERAPY	0.396781	104,953	0	0	41,643	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.038684	3,571,627	0	22	138,165	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.098934	273,928	0	0	27,101	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327466	4,119,718	0	0	1,349,068	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251274	3,522,237	95,912	0	885,047	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196892	1,915,849	0	32,876	377,215	73.00	
74.00	07400	RENAL DIALYSIS	0.291722	92,420	0	0	26,961	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.323407	394,696	0	0	127,647	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	0.338275	955,914	0	2,055	323,362	90.00	
91.00	09100	EMERGENCY	0.146017	4,436,402	0	40	647,790	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	0.585596	205,659	0	0	120,433	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192363	2,137,775	0	3	411,229	92.00	
200.00		Subtotal (see instructions)		72,901,709	95,912	64,431	11,861,106	200.00	
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00	
		Only Charges							
202.00		Net Charges (line 200 - line 201)		72,901,709	95,912	64,431	11,861,106	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/28/2020 12:16 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	598		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,738		55.00
57.00	05700	CT SCAN	0	478		57.00
58.00	05800	MRI	0	168		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	396		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1		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	24,100	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,473		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	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	695		90.00
91.00	09100	EMERGENCY	0	6		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1		92.00
200.00		Subtotal (see instructions)	24,100	10,559		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	24,100	10,559		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 12:16 pm	
				Title XVIII		Skilled Nursing Facility		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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
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
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
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	627,090	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		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
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	627,090	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 12:16 pm	
			Title XVIII		Skilled Nursing Facility		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	109,770,545	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	12,205,820	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	22,553,393	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,381,129	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,671,801	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,619,306	0.000000	57.00
58.00	05800	MRI	0	0	0	12,724,656	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	25,192,608	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	71,174,943	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,868,360	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,479,643	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,508,224	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,968,941	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,415,768	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	39,597,650	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,478,354	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	627,090	627,090	72,999,105	0.008590	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,768,890	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	696,074	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	3,814,738	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,044,092	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	952,482	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,057,362	0.000000	92.00
200.00		Total (lines 50 through 199)	0	627,090	627,090	599,943,884		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/28/2020 12:16 pm	
				Title XVIII		Skilled Nursing Facility		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		67,977	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		3,066	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000		2,667	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		150,352	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000		17,492	0	0	0	57.00
58.00	05800	MRI	0.000000		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		21,568	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		1,211,488	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		7,392	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		117,569	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		3,966,260	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		86,895	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		5,527	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		463,143	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	0.008590		2,231,970	19,173	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	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		687	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000		0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000		0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			8,354,053	19,173	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-5568

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/28/2020 12:16 pm

Title XVIII

Skilled Nursing
Facility

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	0.180805	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.147963	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.028282	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.166646	0	0	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.177163	0	0	0	0 55.00
57.00	05700 CT SCAN	0.043321	0	0	10	0 57.00
58.00	05800 MRI	0.061371	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.158376	0	0	7	0 59.00
60.00	06000 LABORATORY	0.156903	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.014828	0	0	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.287410	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.396781	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.038684	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.098934	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.327466	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.251274	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196892	0	0	4,545	0 73.00
74.00	07400 RENAL DIALYSIS	0.291722	0	0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.323407	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	0.338275	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.146017	0	0	0	0 91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.585596	0	0	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.192363	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	4,562	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	4,562	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-5568

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
11/28/2020 12:16 pm

Title XVIII

Skilled Nursing
Facility

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	895	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	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
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	896	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	896	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 12:16 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)		41,089	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		41,089	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)		39,128	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)		10,743	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)		60,690,220	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)		60,690,220	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)		60,690,220	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)		1,477.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,867,841	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)		15,867,841	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 12:16 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	8,458,500	2,584	3,273.41	1,313	4,297,987	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)					15,614,178	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					35,780,006	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)					2,549,489	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,298,240	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,847,729	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					31,932,277	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)					1,961	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,477.04	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,896,475	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,927,172	60,690,220	0.130617	2,896,475	378,329
91.00	Nursing School cost	0	60,690,220	0.000000	2,896,475	0
92.00	Allied health cost	0	60,690,220	0.000000	2,896,475	0
93.00	All other Medical Education	0	60,690,220	0.000000	2,896,475	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 12:16 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,389	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,389	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)		5,389	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,738	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)		6,773,739	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)		6,773,739	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)		6,773,739	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 12:16 pm	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					6,773,739	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					1,256.96	71.00
72.00	Program routine service cost (line 9 x line 71)					4,698,516	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					4,698,516	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					4,698,516	83.00
84.00	Program inpatient ancillary services (see instructions)					2,435,035	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					7,133,551	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224
Component CCN: 14-5568

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

Worksheet D-1
Date/Time Prepared:
11/28/2020 12:16 pm
PPS

Title XVIII

Skilled Nursing
Facility

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/28/2020 12:16 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			41,089 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			41,089 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)			39,128 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)			637 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)			2,176 15.00
16.00	Nursery days (title V or XIX only)			53 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)			60,690,220 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)			60,690,220 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)			60,690,220 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)			1,477.04 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			940,874 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)			940,874 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:
11/28/2020 12:16 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)	5,740,162	2,176	2,637.94	53	139,811	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	8,458,500	2,584	3,273.41	86	281,513	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)						1,362,198	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)						1,961	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,477.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,896,475	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		Title XIX		Hospital		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	7,927,172	60,690,220	0.130617	2,896,475	378,329
91.00	Nursing School cost	0	60,690,220	0.000000	2,896,475	0
92.00	Allied health cost	0	60,690,220	0.000000	2,896,475	0
93.00	All other Medical Education	0	60,690,220	0.000000	2,896,475	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 12:16 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		34,833,072	30.00
31.00	03100	INTENSIVE CARE UNIT		6,735,228	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.180805	8,690,723	50.00
51.00	05100	RECOVERY ROOM	0.147963	1,500,742	51.00
53.00	05300	ANESTHESIOLOGY	0.028282	1,694,752	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166646	2,809,398	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.177163	166,735	55.00
57.00	05700	CT SCAN	0.043321	3,854,156	57.00
58.00	05800	MRI	0.061371	835,480	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.158376	5,462,059	59.00
60.00	06000	LABORATORY	0.156903	13,185,310	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.014828	534,072	63.00
65.00	06500	RESPIRATORY THERAPY	0.287410	3,591,684	65.00
66.00	06600	PHYSICAL THERAPY	0.396781	1,685,412	66.00
69.00	06900	ELECTROCARDIOLOGY	0.038684	4,057,504	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.098934	157,268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.327466	6,075,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251274	6,280,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.196892	16,629,090	73.00
74.00	07400	RENAL DIALYSIS	0.291722	802,277	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.323407	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.338275	29,863	90.00
91.00	09100	EMERGENCY	0.146017	7,324,727	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.585596	3,708	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192363	437,086	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		85,807,590	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)		85,807,590	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/28/2020 12:16 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		265		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.180805	67,977	12,291	50.00
51.00	05100 RECOVERY ROOM	0.147963	3,066	454	51.00
53.00	05300 ANESTHESIOLOGY	0.028282	2,667	75	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.166646	150,352	25,056	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.177163	0	0	55.00
57.00	05700 CT SCAN	0.043321	17,492	758	57.00
58.00	05800 MRI	0.061371	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.158376	21,568	3,416	59.00
60.00	06000 LABORATORY	0.156903	1,211,488	190,086	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.014828	7,392	110	63.00
65.00	06500 RESPIRATORY THERAPY	0.287410	117,569	33,791	65.00
66.00	06600 PHYSICAL THERAPY	0.396781	3,966,260	1,573,737	66.00
69.00	06900 ELECTROCARDIOLOGY	0.038684	86,895	3,361	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.098934	5,527	547	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.327466	463,143	151,664	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.251274	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.196892	2,231,970	439,457	73.00
74.00	07400 RENAL DIALYSIS	0.291722	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.323407	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	0.338275	687	232	90.00
91.00	09100 EMERGENCY	0.146017	0	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.585596	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.192363	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,354,053	2,435,035	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)		8,354,053		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/28/2020 12:16 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)		5,422,417	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,169,398	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)		100,671	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		313,294	2.04
3.00	Managed Care Simulated Payments		7,348,868	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		242.81	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)		139.15	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)		22.76	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.		0.64	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).		-16.00	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)		7.00	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)		106.75	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		101.26	10.00
11.00	FTE count for residents in dental and podiatric programs.		14.89	11.00
12.00	Current year allowable FTE (see instructions)		116.15	12.00
13.00	Total allowable FTE count for the prior year.		118.77	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.		117.73	14.00
15.00	Sum of lines 12 through 14 divided by 3.		117.55	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		117.55	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.484123	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.452061	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.452061	21.00
22.00	IME payment adjustment (see instructions)		4,312,903	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,617,765	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)		-5.49	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)		4,312,903	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,617,765	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.27	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.55	31.00
32.00	Sum of lines 30 and 31		29.82	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.82	33.00
34.00	Disproportionate share adjustment (see instructions)		676,898	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/28/2020 12:16 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)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,691,203	1,053,614		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	426,276	788,771		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,215,047			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)	26,210,628			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)			27,828,393	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			2,318,905	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).			4,877,295	52.00
53.00	Nursing and Allied Health Managed Care payment			25,864	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			142,844	58.00
59.00	Total (sum of amounts on lines 49 through 58)			35,193,301	59.00
60.00	Primary payer payments			28,908	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			35,164,393	61.00
62.00	Deductibles billed to program beneficiaries			2,198,240	62.00
63.00	Coinsurance billed to program beneficiaries			156,684	63.00
64.00	Allowable bad debts (see instructions)			789,975	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			513,484	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			532,172	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			33,322,953	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)			74,364	70.93
70.94	HRR adjustment amount (see instructions)			-93,847	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 11/28/2020 12:16 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)		33,303,470	71.00
71.01	Sequestration adjustment (see instructions)		556,168	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		31,926,829	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)		820,473	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		741,696	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2020 12:16 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	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,422,417	0	5,422,417		5,422,417	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,169,398	0		14,169,398	14,169,398	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	100,671	0	100,671		100,671	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	313,294	0		313,294	313,294	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	7,348,868	0	1,802,664	5,546,204	7,348,868	4.00	
Indirect Medical Education Adjustment									
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.452061	0.452061	0.452061	0.452061		5.00	
6.00	IME payment adjustment (see instructions)	22.00	4,312,903	0	1,193,680	3,119,223	4,312,903	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,617,765	0	396,835	1,220,930	1,617,765	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	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	4,312,903	0	1,193,680	3,119,223	4,312,903	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,617,765	0	396,835	1,220,930	1,617,765	9.01	
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1382	0.1382	0.1382	0.1382		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	676,898	0	187,345	489,553	676,898	11.00	
11.01	Uncompensated care payments	36.00	1,215,047	0	2,560,008	0	2,560,008	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	0	12.00	
13.00	Subtotal (see instructions)	47.00	26,210,628	0	9,464,121	16,746,507	26,210,628	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	27,828,393	0	9,860,956	17,967,437	27,828,393	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,318,905	0	645,269	1,673,636	2,318,905	16.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2020 12:16 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	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	10,506,225	19,641,073	30,147,298
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,549,761	0	441,138	1,108,623	1,549,761
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	155,904	0	29,573	126,331	155,904
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.3334	0.3334	0.3334	0.3334	
23.00	Indirect medical education adjustment (see instructions)	6.00	516,690	0	147,075	369,615	516,690
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0623	0.0623	0.0623	0.0623	
25.00	Disproportionate share adjustment (see instructions)	11.00	96,550	0	27,483	69,067	96,550
26.00	Total prospective capital payments (see instructions)	12.00	2,318,905	0	645,269	1,673,636	2,318,905
		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	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2020 12:16 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	5,422,417	5,422,417		5,422,417	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,169,398		14,169,398	14,169,398	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	100,671	100,671		100,671	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	313,294		313,294	313,294	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,348,868	1,802,664	5,546,204	7,348,868	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.452061	0.452061	0.452061		5.00
6.00	IME payment adjustment (see instructions)	22.00	4,312,903	1,193,680	3,119,223	4,312,903	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,617,765	396,835	1,220,930	1,617,765	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	4,312,903	1,193,680	3,119,223	4,312,903	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,617,765	396,835	1,220,930	1,617,765	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1382	0.1382	0.1382		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	676,898	187,345	489,553	676,898	11.00
11.01	Uncompensated care payments	36.00	1,215,047	469,017	1,264,927	1,733,944	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	26,210,628	7,373,130	18,837,498	26,210,628	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	27,828,393	7,769,965	20,058,428	27,828,393	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,318,905	645,269	1,673,636	2,318,905	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,415,234	21,732,064	30,147,298	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2020 12:16 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,549,761	441,138	1,108,623	1,549,761	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	155,904	29,573	126,331	155,904	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	0.3334	0.3334	0.3334		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	516,690	147,075	369,615	516,690	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0623	0.0623	0.0623		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	96,550	27,483	69,067	96,550	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,318,905	645,269	1,673,636	2,318,905	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	74,364	13,521	60,843	74,364	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	-93,847	-42,837	-51,010	-93,847	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: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/28/2020 12:16 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		34,659	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,844,649	2.00
3.00	OPPS payments		9,080,918	3.00
4.00	Outlier payment (see instructions)		87,441	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		16,457	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		34,659	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		160,343	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)		160,343	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)		160,343	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		125,684	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)		34,659	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)		9,184,816	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		19,182	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,738,529	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)		7,461,764	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,359,352	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)		8,821,116	30.00
31.00	Primary payer payments		1,436	31.00
32.00	Subtotal (line 30 minus line 31)		8,819,680	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)		448,728	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		291,673	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		319,519	36.00
37.00	Subtotal (see instructions)		9,111,353	37.00
38.00	MSP-LCC reconciliation amount from PS&R		41	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		9,111,312	40.00
40.01	Sequestration adjustment (see instructions)		152,159	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		9,049,814	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-90,661	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/28/2020 12:16 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		896	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		896	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,562	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		4,562	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		4,562	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,666	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)		896	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		896	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)		896	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		896	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		896	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		896	40.00
40.01	Sequestration adjustment (see instructions)		15	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		1,163	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-282	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/28/2020 12:16 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		26,693,678		7,301,040	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		5,162,715		1,592,979	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/17/2020	70,436	02/17/2020	155,795	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		70,436		155,795	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)		31,926,829		9,049,814	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		820,473		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		90,661	6.02
7.00	Total Medicare program liability (see instructions)		32,747,302		8,959,153	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0224
 Component CCN: 14-5568

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/28/2020 12:16 pm

		Title XVIII		Skilled Nursing Facility	PPS
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				
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		2,044,395		1,163
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)		0		0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		2,044,395		1,163
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		21,167		0
6.02	SETTLEMENT TO PROGRAM		0		282
7.00	Total Medicare program liability (see instructions)		2,065,562		881
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor	0			

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/28/2020 12:16 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: 14-0224 Component CCN: 14-5568	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2020 12:16 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			2,210,859 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			19,173 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,230,032 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			130,796 7.00
8.00	Allowable bad debts (see instructions)			3,069 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			1,995 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			2,101,231 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			2,101,231 15.00
15.01	Sequestration adjustment (see instructions)			35,669 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			33 15.75
16.00	Interim payments			2,044,395 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			21,134 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2020 12:16 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	1,362,198			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)	1,362,198		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)	1,362,198		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)	1,362,198		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)	1,362,198		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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0224		Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 11/28/2020 12:16 pm	
		Title XVIII		Hospital		PPS
						1.00
COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					142.44 1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00 2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					23.61 3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					1.79 3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					-20.00 4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					7.00 4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					104.04 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					101.26 6.00
7.00	Enter the lesser of line 5 or line 6					101.26 7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	87.34	13.42	100.76		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	87.34	13.42	100.76		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		14.44			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01
11.00	Total weighted FTE count	87.34	27.86			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	88.20	29.03			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	89.09	27.51			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	88.21	28.13			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	88.21	28.13			17.00
18.00	Per resident amount	141,378.31	136,273.81			18.00
19.00	Approved amount for resident costs	12,470,981	3,833,382	16,304,363		19.00
				1.00		
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00		21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00
24.00	Multiply line 22 time line 23			0		24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			16,304,363		25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD						
26.00	Inpatient Days (see instructions)	12,056	2,092	2,300	26.00	
27.00	Total Inpatient Days (see instructions)	42,196	42,196	42,196	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.285714	0.049578	0.054508	28.00	
29.00	Program direct GME amount	4,658,385	808,338	888,718	6,355,441	29.00
29.01	Percent reduction for MA DGME		7.00	7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		56,584	62,210	118,794	30.00
31.00	Net Program direct GME amount				6,236,647	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 11/28/2020 12:16 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,768,890	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			42,708,554	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			28,908	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			42,679,646	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			11,896,661	42.00
43.00	Primary payer payments (see instructions)			1,436	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			11,895,225	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			54,574,871	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.782038	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.217962	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			6,236,647	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			4,877,295	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			1,359,352	50.00

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

Provider CCN: 14-0224

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

Worksheet G

Date/Time Prepared:
11/28/2020 12:16 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	9,701	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	84,098,985	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-62,127,076	0	0	0	6.00
7.00	Inventory	4,458,630	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	644,785	0	0	0	9.00
10.00	Due from other funds	1,775,957	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,860,982	0	0	0	11.00
FIXED ASSETS						
12.00	Land	26,070,000	0	0	0	12.00
13.00	Land improvements	462,328	0	0	0	13.00
14.00	Accumulated depreciation	-123,857	0	0	0	14.00
15.00	Buildings	71,856,365	0	0	0	15.00
16.00	Accumulated depreciation	-5,965,788	0	0	0	16.00
17.00	Leasehold improvements	2,484,822	0	0	0	17.00
18.00	Accumulated depreciation	-331,310	0	0	0	18.00
19.00	Fixed equipment	7,660,951	0	0	0	19.00
20.00	Accumulated depreciation	-1,988,770	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	15,266,887	0	0	0	23.00
24.00	Accumulated depreciation	-6,648,196	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)	108,743,432	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	23,383,679	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	23,383,679	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	160,988,093	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	26,768,601	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	45,550,677	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	72,319,278	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	33,848,243	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	33,848,243	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	106,167,521	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	54,820,572				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	54,820,572	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	160,988,093	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0224

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

Worksheet G-1

Date/Time Prepared:
11/28/2020 12:16 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		91,004,176		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-34,752,423				2.00
3.00	Total (sum of line 1 and line 2)		56,251,753		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	TRANSFER FROM AFFILIATE	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		56,251,753		0		11.00
12.00	NET ASSET TRANSFER	1,431,181		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)		1,431,181		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		54,820,572		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	TRANSFER FROM AFFILIATE		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	NET ASSET TRANSFER		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: 14-0224

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2020 12:16 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	146,928,135		146,928,135	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	6,522,283		6,522,283	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)	153,450,418		153,450,418	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	16,788,614		16,788,614	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)	16,788,614		16,788,614	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	170,239,032		170,239,032	17.00
18.00	Ancillary services	238,398,764	297,676,446	536,075,210	18.00
19.00	Outpatient services	19,841,280	44,027,395	63,868,675	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER MISC REVENUES	683,809	12,883,901	13,567,710	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	429,162,885	354,587,742	783,750,627	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		221,303,646		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	RECONCILING ITEM	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)		221,303,646		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0224

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

Worksheet G-3

Date/Time Prepared:
11/28/2020 12:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	783,750,627	1.00
2.00	Less contractual allowances and discounts on patients' accounts	605,017,774	2.00
3.00	Net patient revenues (line 1 minus line 2)	178,732,853	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	221,303,646	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-42,570,793	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	56,614	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	746,596	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	REVENUE FROM OTHER SOURCES	3,071,643	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	65,989	24.01
24.50	COVID-19 PHE Funding	3,877,528	24.50
25.00	Total other income (sum of lines 6-24)	7,818,370	25.00
26.00	Total (line 5 plus line 25)	-34,752,423	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-34,752,423	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0224	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 11/28/2020 12:16 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,549,761	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		155,904	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)		115.29	3.00
4.00	Number of interns & residents (see instructions)		117.55	4.00
5.00	Indirect medical education percentage (see instructions)		33.34	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)		516,690	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		7.27	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.55	8.00
9.00	Sum of lines 7 and 8		29.82	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.23	10.00
11.00	Disproportionate share adjustment (see instructions)		96,550	11.00
12.00	Total prospective capital payments (see instructions)		2,318,905	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