

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: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 5/25/2021 11:11 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/25/2021	Time: 11:11 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL EAST (14-0307) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

VICE PRESIDENT OF FINANCE

Title

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	732,523	94,227	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	732,523	94,227	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: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/25/2021 11:11 am

1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1404 CROSS STREET			PO Box:						1.00	
2.00	City: SHILOH			State: IL		Zip Code: 62269		County: ST. CLAIR		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			MEMORIAL HOSPITAL EAST	140307	41180	1	05/16/2016	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							01/01/2020	12/31/2020		
21.00	Type of Control (see instructions)							2			
								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				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y				
22.02	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				
22.03	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		
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				
				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.			803	993	17	10	3,346	834		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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	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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					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.					N		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.							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.							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.				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/25/2021 11:11 am
			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/25/2021 11:11 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,050,000	470,000	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	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	5.00	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1804	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0307		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/25/2021 11:11 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: BJC HEALTHCARE		Contractor's Name: WPS		Contractor's Number: 05301				141.00
142.00	Street: 4901 FOREST PARK PARKWAY		PO Box:						142.00
143.00	City: ST. LOUIS		State: MO		Zip Code: 63108				143.00
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									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		Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
									1.00
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
									1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y
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)								
168.01	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)								
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)								1.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 5/25/2021 11:11 am
			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.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 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)	Y	03/29/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
5/25/2021 11:11 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MELINDA		HERNANDEZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	BJC HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-362-0616		MELINDA.HERNANDEZ@BJC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	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: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/25/2021 11:11 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,208	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)		88	32,208	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	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)		94	34,404	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		94			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/25/2021 11:11 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,905	287	11,917			1.00
2.00	HMO and other (see instructions)	2,284	5,099				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)	3,905	287	11,917			7.00
8.00	INTENSIVE CARE UNIT	339	15	852			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		526	3,979			13.00
14.00	Total (see instructions)	4,244	828	16,748	0.00	540.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	540.73	27.00
28.00	Observation Bed Days		22	737			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	76	1,130			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/25/2021 11:11 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	991	353	5,688	1.00
2.00 HMO and other (see instructions)			572	2,279		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	991	353	5,688	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
5/25/2021 11:11 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	33,916,415	0	33,916,415	997,835.41	33.99
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		147,174	3,350	150,524	9,313.35	16.16
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		467,452	0	467,452	4,152.35	112.58
12.00	Contract labor: Top level management and other management and administrative services		20,795	0	20,795	277.26	75.00
13.00	Contract labor: Physician-Part A - Administrative		494,289	0	494,289	2,975.24	166.13
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		5,312,641	0	5,312,641	138,840.00	38.26
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,052,956	0	8,052,956		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		34,944	0	34,944		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		857,516	0	857,516		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
5/25/2021 11:11 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	148,097	-18,000	130,097	3,398.44	38.28	26.00
27.00	Administrative & General	5.00	3,380,591	-325,700	3,054,891	87,283.45	35.00	27.00
28.00	Administrative & General under contract (see inst.)		331,027	0	331,027	10,385.91	31.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	170,664	3,000	173,664	4,512.39	38.49	30.00
31.00	Laundry & Linen Service	8.00	0	74,077	74,077	4,548.00	16.29	31.00
32.00	Housekeeping	9.00	839,272	-54,277	784,995	52,597.99	14.92	32.00
33.00	Housekeeping under contract (see instructions)		258,545	0	258,545	6,248.33	41.38	33.00
34.00	Dietary	10.00	426,318	9,300	435,618	25,714.26	16.94	34.00
35.00	Dietary under contract (see instructions)		283,993	0	283,993	6,491.35	43.75	35.00
36.00	Cafeteria	11.00	80,887	0	80,887	4,739.60	17.07	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,479,426	-75,166	1,404,260	27,233.68	51.56	38.00
39.00	Central Services and Supply	14.00	176,500	3,000	179,500	7,769.99	23.10	39.00
40.00	Pharmacy	15.00	1,550,821	14,000	1,564,821	36,286.94	43.12	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	186,033	2,250	188,283	6,374.59	29.54	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
5/25/2021 11:11 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	34,789,980	0	34,789,980	1,020,961.00	34.08	1.00
2.00	Excluded area salaries (see instructions)	147,174	3,350	150,524	9,313.35	16.16	2.00
3.00	Subtotal salaries (line 1 minus line 2)	34,642,806	-3,350	34,639,456	1,011,647.65	34.24	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,295,177	0	6,295,177	146,244.85	43.05	4.00
5.00	Subtotal wage-related costs (see inst.)	8,910,472	0	8,910,472	0.00	25.72	5.00
6.00	Total (sum of lines 3 thru 5)	49,848,455	-3,350	49,845,105	1,157,892.50	43.05	6.00
7.00	Total overhead cost (see instructions)	9,312,174	-367,516	8,944,658	283,584.92	31.54	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Prepared: 5/25/2021 11:11 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,381,230	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)		2,903,613	8.02
8.03	Health Insurance (Purchased)		12,022	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		102,552	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		19,509	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)		433,610	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		34,292	14.00
15.00	'Workers' Compensation Insurance		494,081	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		2,451,294	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		98,156	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		122,597	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		8,052,956	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	467,452	8,052,956	1.00
2.00	Hospital	467,452	8,052,956	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 5/25/2021 11:11 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.205788		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		9,499,852		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,472,176		5.00
6.00	Medicaid charges		69,890,648		6.00
7.00	Medicaid cost (line 1 times line 6)		14,382,657		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)		3,410,629		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)		3,410,629		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)	3,846,192	1,019,765	4,865,957	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	791,500	1,019,765	1,811,265	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)	791,500	1,019,765	1,811,265	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)		5,638,009		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		216,595		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		333,224		27.01
28.00	Non-Medicare bad debt expense (see instructions)		5,304,785		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,208,290		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,019,555		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,430,184		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0307

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

Worksheet A

Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	9,744,640	9,744,640	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	0	939,587	939,587	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	7,914,975	7,914,975	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	148,097	756,434	904,531	8,699,125	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,380,591	21,164,009	24,544,600	15,064,067	5.00
7.00	00700	OPERATION OF PLANT	170,664	3,070,087	3,240,751	3,101,854	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	269,952	269,952	8.00
9.00	00900	HOUSEKEEPING	839,272	1,064,144	1,903,416	1,317,480	9.00
10.00	01000	DIETARY	426,318	757,257	1,183,575	836,343	10.00
11.00	01100	CAFETERIA	80,887	136,931	217,818	305,951	11.00
13.00	01300	NURSING ADMINISTRATION	1,479,426	701,866	2,181,292	1,506,268	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	176,500	606,485	782,985	578,846	14.00
15.00	01500	PHARMACY	1,550,821	2,966,692	4,517,513	1,661,039	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	531,679	531,679	531,679	16.00
17.00	01700	SOCIAL SERVICE	186,033	89,067	275,100	233,240	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,047,510	5,292,608	13,340,118	8,386,724	30.00
31.00	03100	INTENSIVE CARE UNIT	1,225,220	438,044	1,663,264	1,312,524	31.00
43.00	04300	NURSERY	1,088,282	326,250	1,414,532	3,446,298	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,755,456	4,796,466	7,551,922	3,638,724	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,428,804	2,428,804	2,300,367	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,357,474	6,937,710	11,295,184	6,786,675	54.00
57.00	05700	CT SCAN	395,810	1,125,227	1,521,037	430,605	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	153,889	508,657	662,546	175,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,600,851	4,213,057	5,813,908	4,773,644	60.00
65.00	06500	RESPIRATORY THERAPY	888,536	482,913	1,371,449	1,039,800	65.00
66.00	06600	PHYSICAL THERAPY	1,071,676	399,856	1,471,532	1,099,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,391,816	3,391,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,829,174	2,829,174	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,168,757	2,168,757	73.00
74.00	07400	RENAL DIALYSIS	0	105,809	105,809	105,809	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,745,928	1,511,915	5,257,843	4,108,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	-1,149,291	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	3,658,762	3,658,762	182,894	113.00
118.00	11800	SUBTOTALS (SUM OF LINES 1 through 117)	33,769,241	64,070,729	97,839,970	98,881,998	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	147,174	1,387,681	1,534,855	492,827	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	33,916,415	65,458,410	99,374,825	99,374,825	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0307

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

Worksheet A

Date/Time Prepared:
5/25/2021 11:11 am

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	966,437	10,711,077	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	939,587	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	299,501	8,214,476	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	889,153	9,588,278	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	246,982	15,311,049	5.00
7.00	00700	OPERATION OF PLANT	-105,678	2,996,176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	269,952	8.00
9.00	00900	HOUSEKEEPING	0	1,317,480	9.00
10.00	01000	DIETARY	0	836,343	10.00
11.00	01100	CAFETERIA	-226,711	79,240	11.00
13.00	01300	NURSING ADMINISTRATION	-10,634	1,495,634	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-29,307	549,539	14.00
15.00	01500	PHARMACY	-115	1,660,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-528,781	2,898	16.00
17.00	01700	SOCIAL SERVICE	0	233,240	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,905,400	6,481,324	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,312,524	31.00
43.00	04300	NURSERY	0	3,446,298	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-625,599	3,013,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-2,246,659	53,708	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,221,262	5,565,413	54.00
57.00	05700	CT SCAN	0	430,605	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	175,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-83,039	4,690,605	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,039,800	65.00
66.00	06600	PHYSICAL THERAPY	-50	1,099,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,391,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,829,174	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,168,757	73.00
74.00	07400	RENAL DIALYSIS	0	105,809	74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-137,005	3,971,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-182,894	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,901,061	93,980,937	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07952	OTHER NRCC	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	492,827	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,901,061	94,473,764	200.00

RECLASSIFICATIONS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet A-6
Date/Time Prepared:
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Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
A - EQUIPMENT RENTAL						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	605,735		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
0			0	605,735		
B - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,391,816		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,829,174		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
0			0	6,220,990		
C - DRUGS SOLD						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,168,757		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
0			0	2,168,757		
D - NURSING FLOAT						
1.00	ADULTS & PEDIATRICS	30.00	83,016	24,832		1.00
0			83,016	24,832		
E - RECLASS CAFETERIA COST						
1.00	CAFETERIA	11.00	0	108,297		1.00
0			0	108,297		
F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,847,912		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.01	0	932,712		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,656,059		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

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RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6

Date/Time Prepared:
5/25/2021 11:11 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
21.00		0.00	0	0		21.00
	0		0	14,436,683		
H - NURSERY/OB						
1.00	NURSERY	43.00	1,894,486	428,025		1.00
	0		1,894,486	428,025		
I - INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	55,793		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.01	0	6,875		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18,248		3.00
	0		0	80,916		
J - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,840,935		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	634,933		2.00
	0		0	3,475,868		
K - HOUSEKEEPING						
1.00	LAUNDRY & LINEN SERVICE	8.00	74,077	195,875		1.00
	0		74,077	195,875		
L - HERO'S PAYMENT						
1.00	ADULTS & PEDIATRICS	30.00	86,350	0		1.00
2.00	OPERATING ROOM	50.00	26,150	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	45,250	0		3.00
4.00	LABORATORY	60.00	21,700	0		4.00
5.00	EMERGENCY	91.00	38,000	0		5.00
6.00	OPERATION OF PLANT	7.00	3,000	0		6.00
7.00	HOUSEKEEPING	9.00	19,800	0		7.00
8.00	DIETARY	10.00	9,300	0		8.00
9.00	NURSING ADMINISTRATION	13.00	7,850	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	3,000	0		10.00
11.00	PHARMACY	15.00	13,500	0		11.00
12.00	SOCIAL SERVICE	17.00	2,250	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	10,750	0		13.00
14.00	NURSERY	43.00	7,500	0		14.00
15.00	CT SCAN	57.00	5,200	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,850	0		16.00
17.00	RESPIRATORY THERAPY	65.00	11,950	0		17.00
18.00	PHYSICAL THERAPY	66.00	8,950	0		18.00
19.00	MEDICAL OFFICE BUILDING 1	194.01	3,350	0		19.00
	TOTALS		325,700	0		
M - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,819,919		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
	0		0	7,819,919		
O - RECRUITMENT RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	1,000	0		1.00
2.00	OPERATING ROOM	50.00	7,000	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	1,000	0		3.00
4.00	LABORATORY	60.00	3,000	0		4.00
5.00	EMERGENCY	91.00	1,250	0		5.00
6.00	PHARMACY	15.00	500	0		6.00
7.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,250	0		7.00
8.00	PHYSICAL THERAPY	66.00	3,000	0		8.00

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RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6

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Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
0		18,000	0			
500.00	Grand Total: Increases	2,395,279	35,565,897			500.00

RECLASSIFICATIONS

Provider CCN: 14-0307

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

Worksheet A-6

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	Decreases						5/25/2021 11:11 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EQUIPMENT RENTAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,276	14		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,005	0		2.00
3.00	PHARMACY	15.00	0	387,010	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	20,327	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,064	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,693	0		6.00
7.00	LABORATORY	60.00	0	126,011	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	24,349	0		8.00
	0		0	605,735			
	B - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	342	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	567,243	0		2.00
3.00	OPERATION OF PLANT	7.00	0	43,253	0		3.00
4.00	HOUSEKEEPING	9.00	0	71,588	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	6,436	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	67,301	0		6.00
7.00	PHARMACY	15.00	0	200,135	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	679,825	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	77,030	0		9.00
10.00	NURSERY	43.00	0	39,800	0		10.00
11.00	OPERATING ROOM	50.00	0	2,947,982	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	29,677	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	754,235	0		13.00
14.00	CT SCAN	57.00	0	30,697	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8,601	0		15.00
16.00	LABORATORY	60.00	0	404,543	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	15,551	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	13,078	0		18.00
19.00	EMERGENCY	91.00	0	229,798	0		19.00
20.00	MEDICAL OFFICE BUILDING 1	194.01	0	33,875	0		20.00
	0		0	6,220,990			
	C - DRUGS SOLD						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,983	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	18,179	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	150	0		3.00
4.00	PHARMACY	15.00	0	1,890,757	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,536	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	409	0		6.00
7.00	OPERATING ROOM	50.00	0	969	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	29,753	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,844	0		9.00
10.00	CT SCAN	57.00	0	168,814	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	18,078	0		11.00
12.00	LABORATORY	60.00	0	1,096	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	110	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	12	0		14.00
15.00	EMERGENCY	91.00	0	67	0		15.00
	0		0	2,168,757			
	D - NURSING FLOAT						
1.00	NURSING ADMINISTRATION	13.00	83,016	24,832	0		1.00
	0		83,016	24,832			
	E - RECLASS CAFETERIA COST						
1.00	DIETARY	10.00	0	108,297	0		1.00
	0		0	108,297			
	F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,701,458	9		1.00
2.00	OPERATION OF PLANT	7.00	0	17,023	9		2.00
3.00	HOUSEKEEPING	9.00	0	3,317	9		3.00
4.00	DIETARY	10.00	0	142,072	0		4.00
5.00	CAFETERIA	11.00	0	3,019	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	270,095	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	60,329	0		7.00
8.00	PHARMACY	15.00	0	49,379	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	271,452	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	61,974	0		10.00
11.00	OPERATING ROOM	50.00	0	397,440	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	69,007	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,754,501	0		13.00
14.00	CT SCAN	57.00	0	792,491	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	436,618	0		15.00

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RECLASSIFICATIONS

Provider CCN: 14-0307

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

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Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
16.00	LABORATORY	60.00	0	135,535	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	48,701	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	119,960	0		18.00
19.00	EMERGENCY	91.00	0	90,809	0		19.00
21.00	MEDICAL OFFICE BUILDING 1	194.01	0	1,011,503	0		21.00
	0		0	14,436,683			
H - NURSERY/OB							
1.00	ADULTS & PEDIATRICS	30.00	1,894,486	428,025	0		1.00
	0		1,894,486	428,025			
I - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,916	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	0		0	80,916			
J - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	3,475,868	14		1.00
2.00		0.00	0	0	14		2.00
	0		0	3,475,868			
K - HOUSEKEEPING							
1.00	HOUSEKEEPING	9.00	74,077	195,875	0		1.00
	0		74,077	195,875			
L - HERO'S PAYMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	325,700	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
	TOTALS		325,700	0			
M - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	749,761	0		1.00
2.00	OPERATION OF PLANT	7.00	0	81,621	0		2.00
3.00	HOUSEKEEPING	9.00	0	260,879	0		3.00
4.00	DIETARY	10.00	0	106,163	0		4.00
5.00	CAFETERIA	11.00	0	17,145	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	298,495	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	74,354	0		7.00
8.00	PHARMACY	15.00	0	343,193	0		8.00
9.00	SOCIAL SERVICE	17.00	0	44,110	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,850,941	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	221,013	0		11.00
12.00	NURSERY	43.00	0	258,445	0		12.00
13.00	OPERATING ROOM	50.00	0	599,957	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,011,486	0		14.00
15.00	CT SCAN	57.00	0	103,630	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	26,891	0		16.00
17.00	LABORATORY	60.00	0	397,779	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	254,888	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	251,301	0		19.00
20.00	EMERGENCY	91.00	0	867,867	0		20.00
	0		0	7,819,919			
O - RECRUITMENT RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,000	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00

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RECLASSIFICATIONS

Provider CCN: 14-0307

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

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Date/Time Prepared:
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	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	0		18,000	0		
500.00	Grand Total: Decreases		2,395,279	35,565,897		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
5/25/2021 11:11 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,200,000	0	0	0	0	1.00	
2.00	Land Improvements	8,896,835	38,157	0	38,157	0	2.00	
3.00	Buildings and Fixtures	127,712,985	4,101,279	0	4,101,279	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	34,084,501	4,989,206	0	4,989,206	7,800	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	179,894,321	9,128,642	0	9,128,642	7,800	8.00	
9.00	Reconciling Items	3,595,386	2,291,594	0	2,291,594	0	9.00	
10.00	Total (line 8 minus line 9)	176,298,935	6,837,048	0	6,837,048	7,800	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,200,000	0				1.00	
2.00	Land Improvements	8,934,992	0				2.00	
3.00	Buildings and Fixtures	131,814,264	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	39,065,907	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	189,015,163	0				8.00	
9.00	Reconciling Items	5,886,980	0				9.00	
10.00	Total (line 8 minus line 9)	183,128,183	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	111,099,043	0	111,099,043	0.689520	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	13,690,151	0	13,690,151	0.084966	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	36,335,934	0	36,335,934	0.225514	0	2.00
3.00	Total (sum of lines 1-2)	161,125,128	0	161,125,128	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	6,847,912	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	932,712	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,656,059	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,436,683	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	689,906	55,793	0	3,117,466	10,711,077	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	6,875	0	0	939,587	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	129,810	18,248	0	1,410,359	8,214,476	2.00
3.00	Total (sum of lines 1-2)	819,716	80,916	0	4,527,825	19,865,140	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0307

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

Worksheet A-8

Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-31,390	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,016	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-11,849	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,998,692			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,086,700			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-53,730	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	B	0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-145	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0307

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

Worksheet A-8

Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	MISC INCOME	B	-1,525	ADULTS & PEDIATRICS		30.00	0	33.00
33.01	MISC. INCOME	B	-360	RADIOLOGY-DIAGNOSTIC		54.00	0	33.01
33.02	MISC. INCOME	B	-54,394	ADMINISTRATIVE & GENERAL		5.00	0	33.02
33.03	ALCOHOLIC BEVERAGES	A	-2,966	ADMINISTRATIVE & GENERAL		5.00	0	33.03
33.04	COFFEE BAR	B	-172,836	CAFETERIA		11.00	0	33.04
33.05	ALCOHOLIC BEVERAGES	A	-33	RADIOLOGY-DIAGNOSTIC		54.00	0	33.05
33.06	CONTRIBUTION	A	-25,797	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.06
33.07	CONTRIBUTION	A	-60	ADMINISTRATIVE & GENERAL		5.00	0	33.07
33.08	CONTRIBUTION	A	-229	ADULTS & PEDIATRICS		30.00	0	33.08
33.09	CONTRIBUTION	A	-50	PHARMACY		15.00	0	33.09
33.10	CONTRIBUTION	A	-1,416	EMERGENCY		91.00	0	33.10
33.11	ADVERTISING	A	-125,000	RADIOLOGY-DIAGNOSTIC		54.00	0	33.11
33.12	MEMBERSHIP DUES	A	-14,103	ADMINISTRATIVE & GENERAL		5.00	0	33.12
33.13	LOBBY EXPENSE	A	-47,841	ADMINISTRATIVE & GENERAL		5.00	0	33.13
33.14	ENTERTAINMENT EXPENSE	A	-4,883	ADMINISTRATIVE & GENERAL		5.00	0	33.14
33.15	AMORTIZED CAPITAL START UP	A	96,285	CAP REL COSTS-BLDG & FIXT		1.00	11	33.15
33.16	AMORITIZED START UP COSTS	A	1,309,797	ADMINISTRATIVE & GENERAL		5.00	11	33.16
33.17	PENSION	A	1,001	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.17
33.18	AMORTIZATION LOSS ON FINANCING	A	625,011	CAP REL COSTS-BLDG & FIXT		1.00	11	33.18
33.19	AMORTIZATION LOSS ON FINANCING	A	136,826	CAP REL COSTS-MVBLE EQUIP		2.00	11	33.19
33.20	MALPRACTICE INSURANCE	A	-1,050,000	ADMINISTRATIVE & GENERAL		5.00	0	33.20
33.21	RENT EXPENSE	A	-314,446	RADIOLOGY-DIAGNOSTIC		54.00	0	33.21
33.22	ALCOHOLIC BEVERAGES	A	-65	PHARMACY		15.00	0	33.22
33.23	CONTRIBUTIONS	A	-50	ADULTS & PEDIATRICS		30.00	0	33.23
33.24	CONTRIBUTIONS	A	-50	PHYSICAL THERAPY		66.00	0	33.24
33.25	RENT	A	-42,152	LABORATORY		60.00	0	33.25
33.26	RENT	A	-195,458	ADMINISTRATIVE & GENERAL		5.00	0	33.26
33.27	MISC. INCOME	B	-145	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,901,061					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: 14-0307

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

Worksheet A-8-1

Date/Time Prepared:

5/25/2021 11:11 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	OTHER EXP.	276,531	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	OTHER EXP.	169,691	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SALARY	317,815	267,885	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	SALARY	4,210,506	3,334,256	3.01
3.02	14.00	CENTRAL SERVICES & SUPPLY	SALARY	316,647	282,164	3.02
3.03	7.00	OPERATION OF PLANT	SALARY	223,237	239,361	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	SALARY	0	347,669	3.04
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	OTHER EXP.	1,079,253	209,255	3.06
3.07	5.00	ADMINISTRATIVE & GENERAL	OTHER EXP.	2,871,317	3,196,168	3.07
3.08	14.00	CENTRAL SERVICES & SUPPLY	OTHER EXP.	27,142	90,932	3.08
3.10	7.00	OPERATION OF PLANT	OTHER EXP.	1,058,553	1,148,107	3.10
3.12	60.00	LABORATORY	REFERENCE LAB BJH	1,721	0	3.12
3.13	60.00	LABORATORY	REFERENCE LAB CHRISTIAN	91,137	65,829	3.13
3.14	5.00	ADMINISTRATIVE & GENERAL	BJC OVERHEAD ALLOCATION	0	8,418	3.14
3.19	16.00	MEDICAL RECORDS & LIBRARY	OTHER EXP.	0	181,112	3.19
3.20	113.00	INTEREST EXPENSE	OTHER EXP.	0	182,894	3.20
3.22	50.00	OPERATING ROOM	MIDWEST SURGICAL TECHNOLOGIE	5,448	8,200	3.22
4.00	5.00	ADMINISTRATIVE & GENERAL	TFC TELEPHONE EXPENSE	7,154	7,202	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,656,152	9,569,452	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	BJC HEALTHCARE	1.00	BJC HEALTHCARE	1.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0307

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

Worksheet A-8-1

Date/Time Prepared:
5/25/2021 11:11 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	276,531	14		1.00
2.00	169,691	14		2.00
3.00	49,930	0		3.00
3.01	876,250	0		3.01
3.02	34,483	0		3.02
3.03	-16,124	0		3.03
3.04	-347,669	0		3.04
3.06	869,998	0		3.06
3.07	-324,851	0		3.07
3.08	-63,790	0		3.08
3.10	-89,554	0		3.10
3.12	1,721	0		3.12
3.13	25,308	0		3.13
3.14	-8,418	0		3.14
3.19	-181,112	0		3.19
3.20	-182,894	0		3.20
3.22	-2,752	0		3.22
4.00	-48	0		4.00
5.00	1,086,700			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	HOME OFFICE		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: 14-0307

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

Worksheet A-8-2

Date/Time Prepared:

5/25/2021 11:11 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	10,567	0	10,567	179,000	55	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	319,672	162,880	156,792	179,000	1,107	2.00
3.00	13.00	NURSING ADMINISTRATION	26,813	0	26,813	179,000	188	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,903,596	1,903,596	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	622,847	622,847	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,246,659	2,246,659	0	239,400	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	922,079	740,150	181,929	271,900	1,076	7.00
8.00	60.00	LABORATORY	136,745	18,557	118,188	260,300	550	8.00
9.00	91.00	EMERGENCY	135,589	135,589	0	179,000	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,324,567	5,830,278	494,289		2,976	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	4,733	237	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	95,266	4,763	0	0	432	2.00
3.00	13.00	NURSING ADMINISTRATION	16,179	809	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	140,656	7,033	0	0	0	7.00
8.00	60.00	LABORATORY	68,829	3,441	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			325,663	16,283	0	0	432	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	4,733	5,834	5,834		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	212	95,478	61,314	224,194		2.00
3.00	13.00	NURSING ADMINISTRATION	0	16,179	10,634	10,634		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,903,596		4.00
5.00	50.00	OPERATING ROOM	0	0	0	622,847		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,246,659		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	140,656	41,273	781,423		7.00
8.00	60.00	LABORATORY	0	68,829	49,359	67,916		8.00
9.00	91.00	EMERGENCY	0	0	0	135,589		9.00
10.00	0.00		0	0	0	0		10.00
200.00			212	325,875	168,414	5,998,692		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0307

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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	10,711,077	10,711,077			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	939,587	0	939,587		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,214,476		8,214,476		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,588,278	10,158	0	4,994	9,603,430
5.00	00500	ADMINISTRATIVE & GENERAL	15,311,049	2,321,063	0	1,141,146	864,586
7.00	00700	OPERATION OF PLANT	2,996,176	936,622	157,348	954,241	72,990
8.00	00800	LAUNDRY & LINEN SERVICE	269,952	0	0	0	21,065
9.00	00900	HOUSEKEEPING	1,317,480	309,580	2,131	158,892	223,223
10.00	01000	DIETARY	836,343	259,667	0	127,665	123,873
11.00	01100	CAFETERIA	79,240	89,669	0	44,086	23,001
13.00	01300	NURSING ADMINISTRATION	1,495,634	46,586	0	22,904	399,318
14.00	01400	CENTRAL SERVICES & SUPPLY	549,539	175,018	0	86,047	51,043
15.00	01500	PHARMACY	1,660,924	148,631	0	73,074	444,976
16.00	01600	MEDICAL RECORDS & LIBRARY	2,898	34,969	0	17,192	0
17.00	01700	SOCIAL SERVICE	233,240	6,130	0	3,014	53,541
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,481,324	2,820,548	0	1,386,716	1,774,517
31.00	03100	INTENSIVE CARE UNIT	1,312,524	281,442	0	138,370	351,463
43.00	04300	NURSERY	3,446,298	92,938	0	45,693	850,319
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,013,125	1,041,060	0	511,835	792,974
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	53,708	94,456	0	46,439	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,565,413	697,271	344,101	1,422,594	1,252,252
57.00	05700	CT SCAN	430,605	61,005	0	29,993	114,032
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	175,458	63,049	0	30,998	44,642
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	4,690,605	142,151	36,074	183,087	462,245
65.00	06500	RESPIRATORY THERAPY	1,039,800	73,206	0	35,992	256,064
66.00	06600	PHYSICAL THERAPY	1,099,081	34,969	57,404	197,323	308,142
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,391,816	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,829,174	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,168,757	0	0	0	0
74.00	07400	RENAL DIALYSIS	105,809	7,297	0	3,588	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,971,547	503,863	0	247,723	1,076,361
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,980,937	10,251,348	597,058	6,913,606	9,560,627
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,877	0	11,739	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	435,852	342,529	1,289,131	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07952	OTHER NRCC	0	0	0	0	0
194.01	07951	MEDICAL OFFICE BUILDING 1	492,827	0	0	0	42,803
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	94,473,764	10,711,077	939,587	8,214,476	9,603,430

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,637,844	19,637,844				5.00
7.00	00700	OPERATION OF PLANT	5,117,377	1,342,861	6,460,238			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	291,017	76,366	0	367,383		8.00
9.00	00900	HOUSEKEEPING	2,011,306	527,791	167,887	0	2,706,984	9.00
10.00	01000	DIETARY	1,347,548	353,613	134,892	0	58,031	10.00
11.00	01100	CAFETERIA	235,996	61,928	46,581	0	20,039	11.00
13.00	01300	NURSING ADMINISTRATION	1,964,442	515,493	24,201	0	10,411	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861,647	226,107	90,919	0	39,113	14.00
15.00	01500	PHARMACY	2,327,605	610,791	77,211	0	33,216	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,059	14,448	18,166	0	7,815	16.00
17.00	01700	SOCIAL SERVICE	295,925	77,654	3,184	0	1,370	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,463,105	3,270,471	1,465,224	147,058	630,343	30.00
31.00	03100	INTENSIVE CARE UNIT	2,083,799	546,814	146,204	10,742	62,897	31.00
43.00	04300	NURSERY	4,435,248	1,163,862	48,280	34,572	20,770	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,358,994	1,406,264	540,812	41,873	232,659	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	194,603	51,066	49,068	0	21,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,281,631	2,435,611	1,503,131	54,156	646,651	54.00
57.00	05700	CT SCAN	635,635	166,798	31,691	0	13,634	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	314,147	82,436	32,753	0	14,090	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,514,162	1,446,982	193,453	0	83,224	60.00
65.00	06500	RESPIRATORY THERAPY	1,405,062	368,705	38,029	0	16,360	65.00
66.00	06600	PHYSICAL THERAPY	1,696,919	445,292	208,495	0	89,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,391,816	890,053	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,829,174	742,409	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,168,757	569,108	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	116,694	30,622	3,791	0	1,631	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,799,494	1,521,857	261,748	78,982	112,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,835,006	18,945,402	5,085,720	367,383	2,115,663	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,616	9,346	12,404	0	5,336	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,067,512	542,540	1,362,114	0	585,985	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	535,630	140,556	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	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,473,764	19,637,844	6,460,238	367,383	2,706,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,894,084					10.00
11.00	01100	CAFETERIA	0	364,544				11.00
13.00	01300	NURSING ADMINISTRATION	0	12,475	2,527,022			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,559	0	1,221,345		14.00
15.00	01500	PHARMACY	0	16,622	0	0	3,065,445	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,920	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,778,005	88,537	821,786	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	116,079	11,746	170,192	0	0	31.00
43.00	04300	NURSERY	0	35,046	572,155	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	30,801	384,539	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,617	95,646	0	0	54.00
57.00	05700	CT SCAN	0	5,381	246	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,861	8	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	27,131	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,090	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,397	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	665,905	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	555,440	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,065,445	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	44,361	482,450	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,894,084	364,544	2,527,022	1,221,345	3,065,445	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	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)	1,894,084	364,544	2,527,022	1,221,345	3,065,445	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,488					16.00
17.00	01700	SOCIAL SERVICE	0	381,053				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,333	355,628	21,030,490	0	21,030,490	30.00
31.00	03100	INTENSIVE CARE UNIT	1,225	25,425	3,175,123	0	3,175,123	31.00
43.00	04300	NURSERY	1,998	0	6,311,931	0	6,311,931	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,582	0	8,004,524	0	8,004,524	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,491	0	318,337	0	318,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,389	0	14,099,832	0	14,099,832	54.00
57.00	05700	CT SCAN	9,692	0	863,077	0	863,077	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,268	0	447,563	0	447,563	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	14,912	0	7,279,864	0	7,279,864	60.00
65.00	06500	RESPIRATORY THERAPY	2,308	0	1,843,554	0	1,843,554	65.00
66.00	06600	PHYSICAL THERAPY	1,678	0	2,454,476	0	2,454,476	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,190	0	4,948,964	0	4,948,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,076	0	4,128,099	0	4,128,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,227	0	5,808,537	0	5,808,537	73.00
74.00	07400	RENAL DIALYSIS	65	0	152,803	0	152,803	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,054	0	8,309,551	0	8,309,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,488	381,053	89,176,725	0	89,176,725	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	62,702	0	62,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,558,151	0	4,558,151	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	676,186	0	676,186	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	95,488	381,053	94,473,764	0	94,473,764	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS			Subtotal	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT	MVBLE EQUIP	
			0	1.00	1.01	2.00	2A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,158	0	4,994	15,152
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,321,063	0	1,141,146	3,462,209
7.00	00700	OPERATION OF PLANT	0	936,622	157,348	954,241	2,048,211
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	0	309,580	2,131	158,892	470,603
10.00	01000	DIETARY	0	259,667	0	127,665	387,332
11.00	01100	CAFETERIA	0	89,669	0	44,086	133,755
13.00	01300	NURSING ADMINISTRATION	0	46,586	0	22,904	69,490
14.00	01400	CENTRAL SERVICES & SUPPLY	0	175,018	0	86,047	261,065
15.00	01500	PHARMACY	0	148,631	0	73,074	221,705
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,969	0	17,192	52,161
17.00	01700	SOCIAL SERVICE	0	6,130	0	3,014	9,144
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,820,548	0	1,386,716	4,207,264
31.00	03100	INTENSIVE CARE UNIT	0	281,442	0	138,370	419,812
43.00	04300	NURSERY	0	92,938	0	45,693	138,631
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,041,060	0	511,835	1,552,895
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	94,456	0	46,439	140,895
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	697,271	344,101	1,422,594	2,463,966
57.00	05700	CT SCAN	0	61,005	0	29,993	90,998
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	63,049	0	30,998	94,047
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	142,151	36,074	183,087	361,312
65.00	06500	RESPIRATORY THERAPY	0	73,206	0	35,992	109,198
66.00	06600	PHYSICAL THERAPY	0	34,969	57,404	197,323	289,696
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	7,297	0	3,588	10,885
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	503,863	0	247,723	751,586
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,251,348	597,058	6,913,606	17,762,012
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,877	0	11,739	35,616
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	435,852	342,529	1,289,131	2,067,512
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07952	OTHER NRCC	0	0	0	0	0
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	0	10,711,077	939,587	8,214,476	19,865,140

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			EMPLOYEE BENEFITS & GENERAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,152					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,365	3,463,574				5.00
7.00	00700	OPERATION OF PLANT	115	236,842	2,285,168			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33	13,469	0	13,502		8.00
9.00	00900	HOUSEKEEPING	352	93,087	59,386	0	623,428	9.00
10.00	01000	DIETARY	196	62,367	47,715	0	13,365	10.00
11.00	01100	CAFETERIA	36	10,922	16,477	0	4,615	11.00
13.00	01300	NURSING ADMINISTRATION	631	90,918	8,560	0	2,398	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	81	39,879	32,161	0	9,008	14.00
15.00	01500	PHARMACY	703	107,726	27,312	0	7,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,548	6,426	0	1,800	16.00
17.00	01700	SOCIAL SERVICE	85	13,696	1,126	0	315	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,789	576,839	518,291	5,404	145,170	30.00
31.00	03100	INTENSIVE CARE UNIT	555	96,442	51,716	395	14,485	31.00
43.00	04300	NURSERY	1,343	205,272	17,078	1,271	4,783	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,252	248,025	191,300	1,539	53,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	9,007	17,357	0	4,862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,977	429,572	531,701	1,990	148,926	54.00
57.00	05700	CT SCAN	180	29,418	11,210	0	3,140	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70	14,539	11,586	0	3,245	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	730	255,206	68,430	0	19,167	60.00
65.00	06500	RESPIRATORY THERAPY	404	65,029	13,452	0	3,768	65.00
66.00	06600	PHYSICAL THERAPY	487	78,537	73,750	0	20,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	156,980	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	130,940	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,374	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,401	1,341	0	376	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,700	268,412	92,588	2,903	25,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,084	3,341,447	1,798,963	13,502	487,245	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,648	4,387	0	1,229	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	95,689	481,818	0	134,954	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	68	24,790	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)	15,152	3,463,574	2,285,168	13,502	623,428	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	510,975					10.00
11.00	01100	CAFETERIA	0	165,805				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,674	177,671			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,619	0	343,813		14.00
15.00	01500	PHARMACY	0	7,560	0	0	372,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,328	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	479,660	40,268	57,779	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	31,315	5,342	11,966	0	0	31.00
43.00	04300	NURSERY	0	15,940	40,227	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,009	27,036	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,661	6,725	0	0	54.00
57.00	05700	CT SCAN	0	2,448	17	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	846	1	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,340	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,954	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,639	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	187,453	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	156,360	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	372,656	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	20,177	33,920	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	510,975	165,805	177,671	343,813	372,656	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	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)	510,975	165,805	177,671	343,813	372,656	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,935					16.00
17.00	01700	SOCIAL SERVICE	0	25,694				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,810	23,980	6,064,254	0	6,064,254	30.00
31.00	03100	INTENSIVE CARE UNIT	808	1,714	634,550	0	634,550	31.00
43.00	04300	NURSERY	1,317	0	425,862	0	425,862	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,656	0	2,095,294	0	2,095,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,642	0	173,763	0	173,763	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,074	0	3,627,592	0	3,627,592	54.00
57.00	05700	CT SCAN	6,388	0	143,799	0	143,799	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,495	0	125,829	0	125,829	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	9,828	0	727,013	0	727,013	60.00
65.00	06500	RESPIRATORY THERAPY	1,522	0	199,327	0	199,327	65.00
66.00	06600	PHYSICAL THERAPY	1,106	0	469,872	0	469,872	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	784	0	345,217	0	345,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	709	0	288,009	0	288,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,445	0	476,475	0	476,475	73.00
74.00	07400	RENAL DIALYSIS	43	0	18,046	0	18,046	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,308	0	1,202,527	0	1,202,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,935	25,694	17,017,429	0	17,017,429	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	42,880	0	42,880	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,779,973	0	2,779,973	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	24,858	0	24,858	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	62,935	25,694	19,865,140	0	19,865,140	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0307

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

Worksheet B-1

Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00			
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	183,477					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	102,726				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			286,203			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	174	0	174	33,771,869		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,759	0	39,759	3,040,442	-19,637,844	5.00
7.00	00700	OPERATION OF PLANT	16,044	17,203	33,247	256,680	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	74,077	0	8.00
9.00	00900	HOUSEKEEPING	5,303	233	5,536	784,995	0	9.00
10.00	01000	DIETARY	4,448	0	4,448	435,618	0	10.00
11.00	01100	CAFETERIA	1,536	0	1,536	80,887	0	11.00
13.00	01300	NURSING ADMINISTRATION	798	0	798	1,404,260	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,998	0	2,998	179,500	0	14.00
15.00	01500	PHARMACY	2,546	0	2,546	1,564,821	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	599	0	599	0	0	16.00
17.00	01700	SOCIAL SERVICE	105	0	105	188,283	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	48,315	0	48,315	6,240,374	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,821	0	4,821	1,235,970	0	31.00
43.00	04300	NURSERY	1,592	0	1,592	2,990,268	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,833	0	17,833	2,788,606	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,618	0	1,618	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,944	37,621	49,565	4,403,724	0	54.00
57.00	05700	CT SCAN	1,045	0	1,045	401,010	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,080	0	1,080	156,989	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,435	3,944	6,379	1,625,551	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,254	0	1,254	900,486	0	65.00
66.00	06600	PHYSICAL THERAPY	599	6,276	6,875	1,083,626	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	125	0	125	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	8,631	0	8,631	3,785,178	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,602	65,277	240,879	33,621,345	-19,637,844	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	409	0	409	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,466	37,449	44,915	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	0	0	0	150,524	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)	10,711,077	939,587	8,214,476	9,603,430		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	58.378309	9.146535	28.701572	0.284362		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				15,152		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000449		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: 14-0307

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

Worksheet B-1

Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	74,835,920				5.00
7.00	00700	OPERATION OF PLANT	5,117,377	213,023			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	291,017	0	359,632		8.00
9.00	00900	HOUSEKEEPING	2,011,306	5,536	0	207,487	9.00
10.00	01000	DIETARY	1,347,548	4,448	0	4,448	10.00
11.00	01100	CAFETERIA	235,996	1,536	0	1,536	11.00
13.00	01300	NURSING ADMINISTRATION	1,964,442	798	0	798	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861,647	2,998	0	2,998	14.00
15.00	01500	PHARMACY	2,327,605	2,546	0	2,546	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,059	599	0	599	16.00
17.00	01700	SOCIAL SERVICE	295,925	105	0	105	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,463,105	48,315	143,955	48,315	30.00
31.00	03100	INTENSIVE CARE UNIT	2,083,799	4,821	10,515	4,821	31.00
43.00	04300	NURSERY	4,435,248	1,592	33,843	1,592	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,358,994	17,833	40,990	17,833	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	194,603	1,618	0	1,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,281,631	49,565	53,013	49,565	54.00
57.00	05700	CT SCAN	635,635	1,045	0	1,045	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	314,147	1,080	0	1,080	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	5,514,162	6,379	0	6,379	60.00
65.00	06500	RESPIRATORY THERAPY	1,405,062	1,254	0	1,254	65.00
66.00	06600	PHYSICAL THERAPY	1,696,919	6,875	0	6,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,391,816	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,829,174	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,168,757	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	116,694	125	0	125	74.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,799,494	8,631	77,316	8,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,197,162	167,699	359,632	162,163	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,616	409	0	409	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,067,512	44,915	0	44,915	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	535,630	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)	19,637,844	6,460,238	367,383	2,706,984	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.262412	30.326481	1.021553	13.046523	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,463,574	2,285,168	13,502	623,428	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.046282	10.727330	0.037544	3.004661	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: 14-0307

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (EMPLOYEE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	795,817					11.00
13.00	01300	NURSING ADMINISTRATION	27,234	319,056				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,770	0	6,220,990			14.00
15.00	01500	PHARMACY	36,287	0	0	2,562,932		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	433,341,918	16.00
17.00	01700	SOCIAL SERVICE	6,375	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	193,279	103,757	0	0	46,967,278	30.00
31.00	03100	INTENSIVE CARE UNIT	25,641	21,488	0	0	5,569,811	31.00
43.00	04300	NURSERY	76,507	72,239	0	0	9,082,733	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,240	48,551	0	0	39,007,015	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	11,321,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,963	12,076	0	0	110,166,206	54.00
57.00	05700	CT SCAN	11,748	31	0	0	44,056,676	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,062	1	0	0	10,307,674	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	59,228	0	0	0	67,780,523	60.00
65.00	06500	RESPIRATORY THERAPY	28,576	0	0	0	10,493,132	65.00
66.00	06600	PHYSICAL THERAPY	27,064	0	0	0	7,628,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,391,816	0	5,408,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,829,174	0	4,888,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,562,932	23,759,748	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	296,646	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	96,843	60,913	0	0	36,606,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	795,817	319,056	6,220,990	2,562,932	433,341,918	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07952	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	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)	364,544	2,527,022	1,221,345	3,065,445	95,488	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.458075	7.920309	0.196326	1.196070	0.000220	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	165,805	177,671	343,813	372,656	62,935	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.208346	0.556865	0.055267	0.145402	0.000145	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: 14-0307

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	
			(PATIENT DAYS)	
			17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	12,769	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	11,917	30.00
31.00	03100	INTENSIVE CARE UNIT	852	31.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,769	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07952	OTHER NRCC	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING 1	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)	381,053	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.842039	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,694	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.012217	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

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Part I
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44,934,422		44,934,422			30.00
31.00	03100	INTENSIVE CARE UNIT	5,569,811		5,569,811			31.00
43.00	04300	NURSERY	9,082,733		9,082,733			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,700,641	32,306,374	39,007,015	0.205207	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,954,288	5,366,947	11,321,235	0.028119	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,488,255	99,677,951	110,166,206	0.127987	0.000000	54.00
57.00	05700	CT SCAN	5,760,023	38,296,653	44,056,676	0.019590	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,304,301	9,003,373	10,307,674	0.043420	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	17,950,948	49,829,575	67,780,523	0.107403	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,948,387	2,544,745	10,493,132	0.175691	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,518,365	6,110,155	7,628,520	0.321750	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,135,433	4,273,554	5,408,987	0.914952	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,535,704	3,353,197	4,888,901	0.844382	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,575,984	6,183,764	23,759,748	0.244470	0.000000	73.00
74.00	07400	RENAL DIALYSIS	282,615	14,031	296,646	0.515102	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,670,062	30,936,771	36,606,833	0.226995	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	442,579	1,590,277	2,032,856	0.602534	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	143,854,551	289,487,367	433,341,918			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	143,854,551	289,487,367	433,341,918			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.205207		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.028119		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128362		54.00
57.00	05700	CT SCAN	0.019590		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043420		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.108132		60.00
65.00	06500	RESPIRATORY THERAPY	0.175691		65.00
66.00	06600	PHYSICAL THERAPY	0.321750		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.914952		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.844382		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244470		73.00
74.00	07400	RENAL DIALYSIS	0.515102		74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.226995		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602534		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,030,490		21,030,490		0	21,030,490	30.00
31.00	03100	INTENSIVE CARE UNIT	3,175,123		3,175,123		0	3,175,123	31.00
43.00	04300	NURSERY	6,311,931		6,311,931		0	6,311,931	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,004,524		8,004,524		0	8,004,524	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0		0	0	52.00
53.00	05300	ANESTHESIOLOGY	318,337		318,337		0	318,337	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,099,832		14,099,832	41,273		14,141,105	54.00
57.00	05700	CT SCAN	863,077		863,077		0	863,077	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	447,563		447,563		0	447,563	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0		0	0	59.00
60.00	06000	LABORATORY	7,279,864		7,279,864	49,359		7,329,223	60.00
65.00	06500	RESPIRATORY THERAPY	1,843,554	0	1,843,554		0	1,843,554	65.00
66.00	06600	PHYSICAL THERAPY	2,454,476	0	2,454,476		0	2,454,476	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,948,964		4,948,964		0	4,948,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,128,099		4,128,099			4,128,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,808,537		5,808,537		0	5,808,537	73.00
74.00	07400	RENAL DIALYSIS	152,803		152,803		0	152,803	74.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	8,309,551		8,309,551		0	8,309,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,224,865		1,224,865			1,224,865	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	90,401,590	0	90,401,590		90,632	90,492,222	200.00
201.00		Less Observation Beds	1,224,865		1,224,865			1,224,865	201.00
202.00		Total (see instructions)	89,176,725	0	89,176,725		90,632	89,267,357	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0307		Period: From 01/01/2020 To 12/31/2020		Worksheet C Part I Date/Time Prepared: 5/25/2021 11:11 am		
					Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
			Inpatient	Outpatient	Total (col. 6 + col. 7)						
			6.00	7.00	8.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	44,934,422		44,934,422					30.00	
31.00	03100	INTENSIVE CARE UNIT	5,569,811		5,569,811					31.00	
43.00	04300	NURSERY	9,082,733		9,082,733					43.00	
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	6,700,641	32,306,374	39,007,015	0.205207	0.000000			50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000			52.00	
53.00	05300	ANESTHESIOLOGY	5,954,288	5,366,947	11,321,235	0.028119	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,488,255	99,677,951	110,166,206	0.127987	0.000000			54.00	
57.00	05700	CT SCAN	5,760,023	38,296,653	44,056,676	0.019590	0.000000			57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,304,301	9,003,373	10,307,674	0.043420	0.000000			58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000			59.00	
60.00	06000	LABORATORY	17,950,948	49,829,575	67,780,523	0.107403	0.000000			60.00	
65.00	06500	RESPIRATORY THERAPY	7,948,387	2,544,745	10,493,132	0.175691	0.000000			65.00	
66.00	06600	PHYSICAL THERAPY	1,518,365	6,110,155	7,628,520	0.321750	0.000000			66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000			67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000			68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000			69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,135,433	4,273,554	5,408,987	0.914952	0.000000			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,535,704	3,353,197	4,888,901	0.844382	0.000000			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	17,575,984	6,183,764	23,759,748	0.244470	0.000000			73.00	
74.00	07400	RENAL DIALYSIS	282,615	14,031	296,646	0.515102	0.000000			74.00	
OUTPATIENT SERVICE COST CENTERS											
91.00	09100	EMERGENCY	5,670,062	30,936,771	36,606,833	0.226995	0.000000			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	442,579	1,590,277	2,032,856	0.602534	0.000000			92.00	
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE								113.00	
200.00		Subtotal (see instructions)	143,854,551	289,487,367	433,341,918					200.00	
201.00		Less Observation Beds								201.00	
202.00		Total (see instructions)	143,854,551	289,487,367	433,341,918					202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		6,064,254	0	6,064,254	12,654	479.24	30.00
31.00	INTENSIVE CARE UNIT		634,550		634,550	852	744.78	31.00
43.00	NURSERY		425,862		425,862	3,979	107.03	43.00
200.00	Total (lines 30 through 199)		7,124,666		7,124,666	17,485		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		3,905	1,871,432				
31.00	INTENSIVE CARE UNIT		339	252,480				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		4,244	2,123,912				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,095,294	39,007,015	0.053716	2,046,796	109,946
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	173,763	11,321,235	0.015348	407,873	6,260
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,627,592	110,166,206	0.032928	5,754,136	189,472
57.00	05700	CT SCAN	143,799	44,056,676	0.003264	2,838,926	9,266
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	125,829	10,307,674	0.012207	552,989	6,750
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	727,013	67,780,523	0.010726	6,075,654	65,167
65.00	06500	RESPIRATORY THERAPY	199,327	10,493,132	0.018996	3,677,626	69,860
66.00	06600	PHYSICAL THERAPY	469,872	7,628,520	0.061594	807,199	49,719
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	345,217	5,408,987	0.063823	313,225	19,991
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	288,009	4,888,901	0.058911	46,511	2,740
73.00	07300	DRUGS CHARGED TO PATIENTS	476,475	23,759,748	0.020054	5,322,784	106,743
74.00	07400	RENAL DIALYSIS	18,046	296,646	0.060833	146,546	8,915
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,202,527	36,606,833	0.032850	2,318,368	76,158
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,196	2,032,856	0.173744	209,511	36,401
200.00		Total (lines 50 through 199)	10,245,959	373,754,952		30,518,144	757,388

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0307		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 5/25/2021 11:11 am		
						Title XVIII		Hospital		PPS		
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
						1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	0	200.00	
Cost Center Description						Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
						4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0	0	12,654	0.00	3,905			30.00	
31.00	03100	INTENSIVE CARE UNIT			0	852	0.00	339			31.00	
43.00	04300	NURSERY			0	3,979	0.00	0			43.00	
200.00		Total (lines 30 through 199)			0	17,485		4,244			200.00	
Cost Center Description						Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
						9.00						
INPATIENT ROUTINE SERVICE COST CENTERS												
30.00	03000	ADULTS & PEDIATRICS		0							30.00	
31.00	03100	INTENSIVE CARE UNIT		0							31.00	
43.00	04300	NURSERY		0							43.00	
200.00		Total (lines 30 through 199)		0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0307		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part IV Date/Time Prepared: 5/25/2021 11:11 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/25/2021 11:11 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	39,007,015	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,321,235	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	110,166,206	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	44,056,676	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10,307,674	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	67,780,523	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,493,132	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,628,520	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,408,987	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,888,901	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,759,748	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	296,646	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	36,606,833	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,032,856	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	373,754,952		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/25/2021 11:11 am

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	2,046,796	0	5,933,382	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	407,873	0	783,289	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,754,136	0	32,070,921	0
57.00	05700	CT SCAN	0.000000	2,838,926	0	9,276,224	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	552,989	0	2,407,456	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.000000	6,075,654	0	3,812,903	0
65.00	06500	RESPIRATORY THERAPY	0.000000	3,677,626	0	681,769	0
66.00	06600	PHYSICAL THERAPY	0.000000	807,199	0	10,416	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	313,225	0	560,113	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	46,511	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,322,784	0	1,866,906	0
74.00	07400	RENAL DIALYSIS	0.000000	146,546	0	10,913	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	2,318,368	0	5,471,613	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	209,511	0	314,550	0
200.00		Total (lines 50 through 199)		30,518,144	0	63,200,455	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/25/2021 11:11 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.205207	5,933,382	0	140	1,217,572	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028119	783,289	0	0	22,025	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127987	32,070,921	0	5,867	4,104,661	54.00
57.00	05700	CT SCAN	0.019590	9,276,224	0	1,397	181,721	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043420	2,407,456	0	279	104,532	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.107403	3,812,903	0	0	409,517	60.00
65.00	06500	RESPIRATORY THERAPY	0.175691	681,769	0	0	119,781	65.00
66.00	06600	PHYSICAL THERAPY	0.321750	10,416	0	0	3,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.914952	560,113	0	0	512,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.844382	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244470	1,866,906	0	6,286	456,403	73.00
74.00	07400	RENAL DIALYSIS	0.515102	10,913	0	0	5,621	74.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.226995	5,471,613	0	0	1,242,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602534	314,550	0	0	189,527	92.00
200.00		Subtotal (see instructions)		63,200,455	0	13,969	8,569,217	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		63,200,455	0	13,969	8,569,217	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/25/2021 11:11 am

				Title XVIII	Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	29		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	751		54.00
57.00	05700	CT SCAN	0	27		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,537		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	2,356		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,356		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/25/2021 11:11 am

				Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.205207	0	444,033	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.028119	0	67,979	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127987	0	1,025,383	0	0	54.00	
57.00	05700	CT SCAN	0.019590	0	445,666	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043420	0	37,841	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.107403	0	823,918	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.175691	0	24,040	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.321750	0	46,114	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.914952	0	64,134	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.844382	0	785	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244470	0	161,572	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.515102	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.226995	0	931,714	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602534	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	4,073,179	0	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	4,073,179	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
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			Title XIX		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	91,119	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,912	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,236	0		54.00
57.00	05700	CT SCAN	8,731	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,643	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	88,491	0		60.00
65.00	06500	RESPIRATORY THERAPY	4,224	0		65.00
66.00	06600	PHYSICAL THERAPY	14,837	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,680	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	663	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,500	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	211,494	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	652,530	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	652,530	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/25/2021 11:11 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,654	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)		11,917	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)		3,905	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)		21,030,490	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)		21,030,490	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)		21,030,490	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)		1,661.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,489,954	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)		6,489,954	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,175,123	852	3,726.67	339	1,263,341
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,167,641
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,920,936
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,123,912
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					757,388
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,881,300
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,039,636
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					737
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,661.96
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,224,865

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	6,064,254	21,030,490	0.288355	1,224,865	353,196	90.00
91.00 Nursing School cost	0	21,030,490	0.000000	1,224,865	0	91.00
92.00 Allied health cost	0	21,030,490	0.000000	1,224,865	0	92.00
93.00 All other Medical Education	0	21,030,490	0.000000	1,224,865	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/25/2021 11:11 am	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,654	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,654	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)		11,917	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)		287	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)		3,979	15.00	
16.00	Nursery days (title V or XIX only)		526	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)		21,030,490	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)		21,030,490	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)		21,030,490	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)		1,661.96	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		476,983	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)		476,983	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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)	6,311,931	3,979	1,586.31	526	834,399	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,175,123	852	3,726.67	15	55,900	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)					377,118	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,744,400	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)					737	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,661.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,224,865	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0307

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

Worksheet D-1

Date/Time Prepared:
5/25/2021 11:11 am

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	6,064,254	21,030,490	0.288355	1,224,865	353,196	90.00
91.00	Nursing School cost	0	21,030,490	0.000000	1,224,865	0	91.00
92.00	Allied health cost	0	21,030,490	0.000000	1,224,865	0	92.00
93.00	All other Medical Education	0	21,030,490	0.000000	1,224,865	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/25/2021 11:11 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		10,951,945		30.00
31.00	03100	INTENSIVE CARE UNIT		2,230,684		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.205207	2,046,796	420,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028119	407,873	11,469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128362	5,754,136	738,612	54.00
57.00	05700	CT SCAN	0.019590	2,838,926	55,615	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043420	552,989	24,011	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.108132	6,075,654	656,973	60.00
65.00	06500	RESPIRATORY THERAPY	0.175691	3,677,626	646,126	65.00
66.00	06600	PHYSICAL THERAPY	0.321750	807,199	259,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.914952	313,225	286,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.844382	46,511	39,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244470	5,322,784	1,301,261	73.00
74.00	07400	RENAL DIALYSIS	0.515102	146,546	75,486	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.226995	2,318,368	526,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602534	209,511	126,238	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,518,144	5,167,641	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)		30,518,144		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/25/2021 11:11 am	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,148,727		30.00
31.00	03100	INTENSIVE CARE UNIT		295,830		31.00
43.00	04300	NURSERY		1,623,895		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.205207	114,769	23,551	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028119	197,959	5,566	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.127987	327,362	41,898	54.00
57.00	05700	CT SCAN	0.019590	164,413	3,221	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.043420	40,769	1,770	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.107403	617,442	66,315	60.00
65.00	06500	RESPIRATORY THERAPY	0.175691	159,673	28,053	65.00
66.00	06600	PHYSICAL THERAPY	0.321750	32,449	10,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.914952	20,335	18,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.844382	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244470	639,857	156,426	73.00
74.00	07400	RENAL DIALYSIS	0.515102	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.226995	93,712	21,272	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.602534	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,408,740	377,118	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)		2,408,740		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A
Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			4,968,277	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,442,174	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)			81,411	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			22,976	2.04
3.00	Managed Care Simulated Payments			4,023,799	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			91.99	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			2.67	30.00
31.00	Percentage of Medicaid patient days (see instructions)			33.58	31.00
32.00	Sum of lines 30 and 31			36.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			222,313	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/25/2021 11:11 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,350,599,096	8,290,014,521 35.00
35.01	Factor 3 (see instructions)		0.000091665	0.000137205 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		765,458	1,137,431 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		573,048	286,695 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		859,743	36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)		8,596,894	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)		8,596,894	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		653,451	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		48,709	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,299,054	59.00
60.00	Primary payer payments		1,111	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,297,943	61.00
62.00	Deductibles billed to program beneficiaries		1,044,164	62.00
63.00	Coinurance billed to program beneficiaries		38,368	63.00
64.00	Allowable bad debts (see instructions)		189,899	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		123,434	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		104,009	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,338,845	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		75,324	70.93
70.94	HRR adjustment amount (see instructions)		-43,040	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/25/2021 11:11 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		93,314	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,277,815	71.00	
71.01	Sequestration adjustment (see instructions)		54,634	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		7,490,658	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)		732,523	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		669,072	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,968,277	0	4,968,277		4,968,277
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,442,174	0		2,442,174	2,442,174
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	81,411	0	81,411		81,411
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	22,976	0		22,976	22,976
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	4,023,799	0	2,651,064	1,372,735	4,023,799
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	222,313	0	149,048	73,265	222,313
11.01	Uncompensated care payments	36.00	859,743	0	740,139	286,175	1,026,314
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	8,596,894	0	5,772,304	2,824,590	8,596,894
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,596,894	0	5,772,304	2,824,590	8,596,894
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	653,451	0	450,551	202,900	653,451

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/25/2021 11:11 am

				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	48,709	0	0	48,709	48,709	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	6,222,855	3,076,199	9,299,054	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	579,622	0	393,843	185,779	579,622	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	73,829	0	56,708	17,121	73,829	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	653,451	0	450,551	202,900	653,451	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,968,277	4,968,277		4,968,277	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,442,174		2,442,174	2,442,174	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	81,411	81,411		81,411	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	22,976		22,976	22,976	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,023,799	2,651,064	1,372,735	4,023,799	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	222,313	149,048	73,265	222,313	11.00
11.01	Uncompensated care payments	36.00	859,743	573,048	286,695	859,743	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	8,596,894	5,771,784	2,825,110	8,596,894	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	8,596,894	5,771,784	2,825,110	8,596,894	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	653,451	450,551	202,900	653,451	16.00
17.00	Special add-on payments for new technologies	54.00	48,709	0	48,709	48,709	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			6,222,335	3,076,719	9,299,054	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	579,622	393,843	185,779	579,622	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	73,829	56,708	17,121	73,829	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	653,451	450,551	202,900	653,451	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	75,324	51,101	24,223	75,324	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	-43,040	-19,377	-23,663	-43,040	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		62,541	30,773	93,314	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0307	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/25/2021 11:11 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,356	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,569,217	2.00
3.00	OPPS payments		7,289,150	3.00
4.00	Outlier payment (see instructions)		2,770	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,356	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		13,969	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)		13,969	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)		13,969	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		11,613	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)		2,356	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)		7,291,920	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)		1,429,732	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)		5,864,544	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)		5,864,544	30.00
31.00	Primary payer payments		8,639	31.00
32.00	Subtotal (line 30 minus line 31)		5,855,905	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)		143,325	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		93,161	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		96,267	36.00
37.00	Subtotal (see instructions)		5,949,066	37.00
38.00	MSP-LCC reconciliation amount from PS&R		322	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,948,744	40.00
40.01	Sequestration adjustment (see instructions)		39,262	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		5,815,255	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		94,227	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
5/25/2021 11:11 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,490,658		5,815,255	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,490,658		5,815,255	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		732,523		94,227	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,223,181		5,909,482	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part II
Date/Time Prepared:
5/25/2021 11:11 am

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

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

Provider CCN: 14-0307

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

Worksheet G

Date/Time Prepared:

5/25/2021 11:11 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,300	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	40,385,741	0	0	0	4.00
5.00	Other receivable	134,684	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-27,981,665	0	0	0	6.00
7.00	Inventory	1,120,991	0	0	0	7.00
8.00	Prepaid expenses	126,313	0	0	0	8.00
9.00	Other current assets	979,598	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,767,962	0	0	0	11.00
FIXED ASSETS						
12.00	Land	9,200,000	0	0	0	12.00
13.00	Land improvements	7,208,480	0	0	0	13.00
14.00	Accumulated depreciation	-2,851,107	0	0	0	14.00
15.00	Buildings	117,674,963	0	0	0	15.00
16.00	Accumulated depreciation	-32,022,051	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	36,335,934	0	0	0	23.00
24.00	Accumulated depreciation	-25,972,294	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	24,482,766	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	134,056,691	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	854,493	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	38,326	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	892,819	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	149,717,472	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	736,193	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,508,062	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	14,550,458	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,794,713	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	1,844,016	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,844,016	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,638,729	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	129,078,743				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)	129,078,743	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	149,717,472	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0307

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

Worksheet G-1

Date/Time Prepared:
5/25/2021 11:11 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		140,642,780		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-11,805,824				2.00
3.00	Total (sum of line 1 and line 2)		128,836,956		0		3.00
4.00	TRANSFER FROM BJC	166,787		0		0	4.00
5.00	RELEASE OF RESTRICTED ASSETS	25,000		0		0	5.00
6.00	TEMPORARY RESTRICTED INCOME	50,000		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)		241,787		0		10.00
11.00	Subtotal (line 3 plus line 10)		129,078,743		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		129,078,743		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	TRANSFER FROM BJC		0				4.00
5.00	RELEASE OF RESTRICTED ASSETS		0				5.00
6.00	TEMPORARY RESTRICTED INCOME		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
5/25/2021 11:11 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	72,189,470		72,189,470	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	72,189,470		72,189,470	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,569,811		5,569,811	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)	5,569,811		5,569,811	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	77,759,281		77,759,281	17.00
18.00	Ancillary services	66,154,961	53,076,981	119,231,942	18.00
19.00	Outpatient services	0	237,258,008	237,258,008	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	143,914,242	290,334,989	434,249,231	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		99,374,825		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		99,374,825		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0307

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

Worksheet G-3

Date/Time Prepared:
5/25/2021 11:11 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	434,249,231	1.00
2.00	Less contractual allowances and discounts on patients' accounts	342,088,986	2.00
3.00	Net patient revenues (line 1 minus line 2)	92,160,245	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	99,374,825	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,214,580	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	84,836	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	226,566	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	5,987	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	160	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	81,756	21.00
22.00	Rental of hospital space	2,220,764	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAID MEANINGFUL USE	0	24.00
24.01	MEDICARE MEANINGFUL USE	0	24.01
24.02	BJC SHARED SERVICES	6,094	24.02
24.03	BJC OTHER OPERATING REVENUE	67,000	24.03
24.04	MISC OTHER REVENUE	-1,415,762	24.04
24.50	COVID-19 PHE Funding	2,000,000	24.50
25.00	Total other income (sum of lines 6-24)	3,277,401	25.00
26.00	Total (line 5 plus line 25)	-3,937,179	26.00
27.00	PHYSICIAN PRACTICE OPERATION BJCMG	7,785,227	27.00
27.01	OTHER EXPENSE/INCOME	75,000	27.01
27.02	BJC ACO OPERATIONS	8,418	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	7,868,645	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-11,805,824	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0307

Period:
From 01/01/2020
To 12/31/2020Worksheet L
Parts I-III
Date/Time Prepared:
5/25/2021 11:11 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	579,622	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	73,829	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)	37.98	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	653,451	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