

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: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 9:54 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE ST. JOSEPH MEDICAL CENTER (14-0007) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 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) YUESHA CHEN
 Officer or Administrator of Provider(s)

REGIONAL CFO-SOUTH REGION
 Title
 (Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,509,534	33,349	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	107,103	90		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	1,616,637	33,439	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: 14-0007		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 9:54 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 333 NORTH MADISON STREET			PO Box:				1.00	
2.00	City: JOLIET			State: IL		Zip Code: 60435		County: KANE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PRESENCE ST. JOSEPH MEDICAL CENTER	140007	20994	1	07/01/1966	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF			SJMC PHYSICAL MED & REHAB	14T007	20994	5	09/07/1987	N
6.00	Subprovider - (Other)							P	O
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? 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.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 9:54 am

MCRIF32 - 16.12.172.6

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 9:54 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
		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
61.01	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)					
61.02	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)					
61.03	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)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					
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)					
61.06	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)					
		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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
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			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	
		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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	44.23	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 9:54 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	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.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	7,261,658		0		0118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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	

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		1.00		2.00			
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		149013		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ALEXIAN BROTHERS HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05901		141.00	
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606		143.00	
				1.00			
144.00	Are provider based physicians' costs included in worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 9:54 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 9:54 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	09/15/2021
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/03/2021	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 9:54 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-451-8283	PATRICK.GILLILAND@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 9:54 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 9:54 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	368	134,320	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)		368	134,320	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	33	12,045	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	24	8,760	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		425	155,125	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	41	14,965		0	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)		466			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)		8	2,920			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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 9:54 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)	23,720	2,546	59,865			1.00
2.00	HMO and other (see instructions)	12,310	11,279				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	1,438	670				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)	23,720	2,546	59,865			7.00
8.00	INTENSIVE CARE UNIT	1,562	273	3,727			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	1,755	272	5,802			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		65	1,406			13.00
14.00	Total (see instructions)	27,037	3,156	70,800	4.23	1,014.78	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	7,815	146	11,220	0.00	51.11	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)			193			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)				4.23	1,065.89	27.00
28.00	Observation Bed Days		237	10,763			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	9	226			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			193			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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 9:54 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	4,951	2,832	14,030	1.00
2.00 HMO and other (see instructions)			1,956	2,490		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				58		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	4,951	2,832	14,030	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	611	122	901	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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 9:54 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	90,020,160	0	90,020,160	2,217,051.85	40.60
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		102,263	0	102,263	613.25	166.76
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		234,900	0	234,900	4,900.50	47.93
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	62,592	62,592	2,080.00	30.09
7.01	Contracted interns and residents (in an approved programs)		500,571	0	500,571	6,718.40	74.51
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)		4,344,271	51,044	4,395,315	124,863.87	35.20
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		11,110,546	0	11,110,546	107,306.38	103.54
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		474,069	0	474,069	4,026.00	117.75
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		119,266,205	0	119,266,205	1,770,242.00	67.37
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)		21,004,657	0	21,004,657		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,207,012	0	1,207,012		
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		11,755	0	11,755		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		51,965	0	51,965		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		51,245	0	51,245		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 9:54 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	41,664	0	41,664	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,882,386	-62,592	3,819,794	74,548.23	51.24	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,037,545	0	1,037,545	47,666.55	21.77	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		3,530,596	0	3,530,596	141,966.00	24.87	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		4,750,878	-2,634,837	2,116,041	76,611.03	27.62	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,429,325	0	3,429,325	73,525.78	46.64	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	3,772,668	-51,044	3,721,624	78,996.47	47.11	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/29/2021 9:54 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)	97,566,163	-2,697,429	94,868,734	2,421,929.98	39.17	1.00
2.00	Excluded area salaries (see instructions)	4,344,271	51,044	4,395,315	124,863.87	35.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)	93,221,892	-2,748,473	90,473,419	2,297,066.11	39.39	3.00
4.00	Subtotal other wages & related costs (see inst.)	130,850,820	0	130,850,820	1,881,574.38	69.54	4.00
5.00	Subtotal wage-related costs (see inst.)	21,016,412	0	21,016,412	0.00	23.23	5.00
6.00	Total (sum of lines 3 thru 5)	245,089,124	-2,748,473	242,340,651	4,178,640.49	58.00	6.00
7.00	Total overhead cost (see instructions)	20,445,062	-2,748,473	17,696,589	493,314.06	35.87	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2021 9:54 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		4,478,961	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		9,155,457	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		183,392	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		64,965	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)		407,189	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,260,453	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		6,524,682	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		73,589	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		177,945	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		22,326,633	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: 14-0007

 Period:
 From 07/01/2020
 To 06/30/2021

 Worksheet S-3
 Part V
 Date/Time Prepared:
 11/29/2021 9:54 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	11,110,546	22,326,633	1.00
2.00	Hospital	11,110,546	21,004,657	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	1,321,976	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

Health Financial Systems		PRESENCE ST. JOSEPH MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/29/2021 9:54 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)			0.179449	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			377,051,742	6.00
7.00	Medicaid cost (line 1 times line 6)			67,661,558	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)			67,661,558	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)			67,661,558	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)	61,980,700	5,744,784	67,725,484	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	11,122,375	5,744,784	16,867,159	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)	11,122,375	5,744,784	16,867,159	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)			8,553,735	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,372,041	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,110,833	27.01
28.00	Non-Medicare bad debt expense (see instructions)			6,442,902	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,894,964	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			18,762,123	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			86,423,681	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 9:54 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		-2,427	-2,427	12,220,194	12,217,767	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,283,717	3,283,717	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	41,664	15,482,810	15,524,474	0	15,524,474	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,882,386	104,635,023	108,517,409	-5,387,394	103,130,015	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,037,545	10,153,758	11,191,303	-466,586	10,724,717	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	773,197	773,197	0	773,197	8.00
9.00	00900	HOUSEKEEPING	0	4,990,010	4,990,010	-21,399	4,968,611	9.00
10.00	01000	DIETARY	0	6,682,229	6,682,229	-3,703,927	2,978,302	10.00
11.00	01100	CAFETERIA	0	0	0	3,692,922	3,692,922	11.00
13.00	01300	NURSING ADMINISTRATION	3,429,325	7,835,550	11,264,875	-338,012	10,926,863	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,348,045	1,348,045	-774,722	573,323	14.00
15.00	01500	PHARMACY	3,772,668	17,531,992	21,304,660	-16,460,950	4,843,710	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,166	2,166	-2,166	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	62,592	62,592	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	500,571	500,571	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	167,836	17,910	185,746	51,044	236,790	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,119,680	9,786,057	42,905,737	-4,599,813	38,305,924	30.00
31.00	03100	INTENSIVE CARE UNIT	3,334,247	2,443,771	5,778,018	-692,424	5,085,594	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,759,070	1,737,927	6,496,997	-446,362	6,050,635	34.00
41.00	04100	SUBPROVIDER - IRF	3,881,263	3,879,273	7,760,536	-2,285,222	5,475,314	41.00
43.00	04300	NURSERY	1,162,962	155,368	1,318,330	260,446	1,578,776	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,953,396	30,819,580	39,772,976	-17,524,505	22,248,471	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,191,172	1,191,172	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,377,096	2,020,867	5,397,963	-1,126,770	4,271,193	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	47	175,850	175,897	-3,432	172,465	55.00
56.00	05600	RADIOISOTOPE	1,397,145	4,193,286	5,590,431	-2,000,564	3,589,867	56.00
57.00	05700	CT SCAN	864,930	554,479	1,419,409	-283,105	1,136,304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	488,512	245,922	734,434	-14,873	719,561	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,787,828	10,016,706	12,804,534	-5,238,766	7,565,768	59.00
60.00	06000	LABORATORY	0	15,157,772	15,157,772	-201,125	14,956,647	60.00
64.00	06400	INTRAVENOUS THERAPY	640,008	99,424	739,432	-41,352	698,080	64.00
65.00	06500	RESPIRATORY THERAPY	2,606,542	1,779,752	4,386,294	-1,221,766	3,164,528	65.00
66.00	06600	PHYSICAL THERAPY	167,908	8,655,958	8,823,866	1,567,338	10,391,204	66.00
69.00	06900	ELECTROCARDIOLOGY	896,521	233,411	1,129,932	-129,758	1,000,174	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	204,211	100,675	304,886	-45,756	259,130	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,417,039	14,417,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,361,058	16,361,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,063,093	17,063,093	73.00
74.00	07400	RENAL DIALYSIS	714,547	630,741	1,345,288	-280,213	1,065,075	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	69,084	75,664	144,748	0	144,748	76.10
76.97	07697	CARDIAC REHABILITATION	264,681	38,164	302,845	-16,636	286,209	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	7,703,886	4,651,381	12,355,267	-1,110,547	11,244,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		6,031,148	6,031,148	-6,031,148	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,724,988	272,933,439	362,658,427	221,893	362,880,320	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	295,172	4,220,939	4,516,111	-221,893	4,294,218	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	90,020,160	277,154,378	367,174,538	0	367,174,538	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 9:54 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	-3,245,795	8,971,972	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,288,006	16,571,723	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	610,087	16,134,561	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,059,776	91,070,239	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,410,603	19,135,320	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,342	801,539	8.00
9.00	00900	HOUSEKEEPING	0	4,968,611	9.00
10.00	01000	DIETARY	-11,456	2,966,846	10.00
11.00	01100	CAFETERIA	-805,585	2,887,337	11.00
13.00	01300	NURSING ADMINISTRATION	265,599	11,192,462	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	573,323	14.00
15.00	01500	PHARMACY	89,010	4,932,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	117,529	117,529	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	62,592	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	500,571	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	236,790	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-321,433	37,984,491	30.00
31.00	03100	INTENSIVE CARE UNIT	390,716	5,476,310	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-55,500	5,995,135	34.00
41.00	04100	SUBPROVIDER - IRF	-103,680	5,371,634	41.00
43.00	04300	NURSERY	0	1,578,776	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,129,353	20,119,118	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,191,172	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,271,193	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-400	172,065	55.00
56.00	05600	RADIOISOTOPE	-3,218	3,586,649	56.00
57.00	05700	CT SCAN	0	1,136,304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	719,561	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,565,768	59.00
60.00	06000	LABORATORY	113,945	15,070,592	60.00
64.00	06400	INTRAVENOUS THERAPY	0	698,080	64.00
65.00	06500	RESPIRATORY THERAPY	-47,888	3,116,640	65.00
66.00	06600	PHYSICAL THERAPY	-6,923	10,384,281	66.00
69.00	06900	ELECTROCARDIOLOGY	-22,700	977,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	259,130	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,417,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,361,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,063,093	73.00
74.00	07400	RENAL DIALYSIS	-21,000	1,044,075	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	-64,600	80,148	76.10
76.97	07697	CARDIAC REHABILITATION	-4,438	281,771	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-2,689,078	8,555,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,721,014	364,601,334	118.00
NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	-2,642,981	1,651,237	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-921,967	366,252,571	200.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/29/2021 9:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,031,148		1.00
	TOTALS		0	6,031,148		
	B - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,395,293		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,283,717		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	8,679,010		
	C - CAFE					
1.00	CAFETERIA	11.00	0	3,692,922		1.00
	TOTALS		0	3,692,922		
	D - LDR					
1.00	NURSERY	43.00	210,930	101,109		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,036,590	154,582		2.00
	TOTALS		1,247,520	255,691		
	E - RADIOLOGY					
1.00	RADIOLOGY - THERAPEUTIC	55.00	3	1,439		1.00
2.00	RADIOISOTOPE	56.00	98,666	17,480		2.00
3.00	CT SCAN	57.00	61,081	1,755		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	34,498	1,641		4.00
	TOTALS		194,248	22,315		
	F - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,063,093		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/29/2021 9:54 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
25.00	0.00	0	0		25.00
26.00	0.00	0	0		26.00
27.00	0.00	0	0		27.00
TOTALS		0	17,063,093		
G - INTERN					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	62,592	0	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	500,571	2.00
TOTALS			62,592	500,571	
H - SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,417,039	1.00
2.00	DIETARY	10.00	0	8,739	2.00
3.00	PHARMACY	15.00	0	121,037	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	113,051	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
TOTALS			0	14,659,866	
I - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,361,058	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
TOTALS			0	16,361,058	
J - REHAB					
1.00	PHYSICAL THERAPY	66.00	0	2,051,873	1.00
TOTALS			0	2,051,873	
K - PHARMA PARAMED					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	51,044	0	1.00
TOTALS			51,044	0	
L - CAPITAL INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	820,528	1.00
TOTALS			0	820,528	
500.00	Grand Total: Increases		1,555,404	70,138,075	500.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
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				
A - INTEREST									
1.00	INTEREST EXPENSE	113.00	0	6,031,148	11			1.00	
TOTALS			0	6,031,148					
B - DEPRECIATION									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,775	9			1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,606,562	9			2.00	
3.00	OPERATION OF PLANT	7.00	0	449,244	0			3.00	
4.00	HOUSEKEEPING	9.00	0	7,136	0			4.00	
5.00	DIETARY	10.00	0	19,744	0			5.00	
6.00	NURSING ADMINISTRATION	13.00	0	237,554	0			6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,932	0			7.00	
8.00	PHARMACY	15.00	0	43,160	0			8.00	
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,166	0			9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	193,310	0			10.00	
11.00	INTENSIVE CARE UNIT	31.00	0	37,629	0			11.00	
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	2,563	0			12.00	
13.00	SUBPROVIDER - IRF	41.00	0	4,914	0			13.00	
14.00	NURSERY	43.00	0	22,228	0			14.00	
15.00	OPERATING ROOM	50.00	0	1,513,060	0			15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	855,150	0			16.00	
17.00	RADIOLOGY - THERAPEUTIC	55.00	0	4,522	0			17.00	
18.00	RADIOISOTOPE	56.00	0	537,006	0			18.00	
19.00	CT SCAN	57.00	0	184,275	0			19.00	
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	28,111	0			20.00	
21.00	CARDIAC CATHETERIZATION	59.00	0	227,971	0			21.00	
22.00	LABORATORY	60.00	0	173,507	0			22.00	
23.00	RESPIRATORY THERAPY	65.00	0	67,327	0			23.00	
24.00	PHYSICAL THERAPY	66.00	0	14,991	0			24.00	
25.00	ELECTROCARDIOLOGY	69.00	0	101,972	0			25.00	
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,002	0			26.00	
27.00	RENAL DIALYSIS	74.00	0	40,193	0			27.00	
28.00	CARDIAC REHABILITATION	76.97	0	14,613	0			28.00	
29.00	EMERGENCY	91.00	0	34,829	0			29.00	
30.00	OTHER NRCC	192.01	0	220,564	0			30.00	
TOTALS			0	8,679,010					
C - CAFE									
1.00	DIETARY	10.00	0	3,692,922	0			1.00	
TOTALS			0	3,692,922					
D - LDR									
1.00	ADULTS & PEDIATRICS	30.00	1,247,520	255,691	0			1.00	
2.00		0.00	0	0	0			2.00	
TOTALS			1,247,520	255,691					
E - RADIOLOGY									
1.00	RADIOLOGY-DIAGNOSTIC	54.00	194,248	22,315	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	
TOTALS			194,248	22,315					
F - PHARMACY									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	257	0			1.00	
2.00	OPERATION OF PLANT	7.00	0	567	0			2.00	
3.00	HOUSEKEEPING	9.00	0	3	0			3.00	
4.00	NURSING ADMINISTRATION	13.00	0	1	0			4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,368	0			5.00	
6.00	PHARMACY	15.00	0	16,486,367	0			6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	129,550	0			7.00	
8.00	INTENSIVE CARE UNIT	31.00	0	16,331	0			8.00	
9.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	20,063	0			9.00	
10.00	SUBPROVIDER - IRF	41.00	0	3,399	0			10.00	
11.00	NURSERY	43.00	0	187	0			11.00	
12.00	OPERATING ROOM	50.00	0	137,827	0			12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	24,045	0			13.00	
14.00	RADIOISOTOPE	56.00	0	23,293	0			14.00	
15.00	CT SCAN	57.00	0	135,633	0			15.00	
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	736	0			16.00	
17.00	CARDIAC CATHETERIZATION	59.00	0	21,281	0			17.00	
18.00	LABORATORY	60.00	0	2	0			18.00	
19.00	INTRAVENOUS THERAPY	64.00	0	3,638	0			19.00	
20.00	RESPIRATORY THERAPY	65.00	0	4,446	0			20.00	
21.00	PHYSICAL THERAPY	66.00	0	257	0			21.00	
22.00	ELECTROCARDIOLOGY	69.00	0	1,436	0			22.00	
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	177	0			23.00	

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/29/2021 9:54 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
24.00	RENAL DIALYSIS	74.00	0	7,573	0	24.00
25.00	CARDIAC REHABILITATION	76.97	0	8	0	25.00
26.00	EMERGENCY	91.00	0	44,644	0	26.00
27.00	OTHER NRCC	192.01	0	4	0	27.00
	TOTALS		0	17,063,093		
G - INTERN						
1.00	ADMINISTRATIVE & GENERAL	5.00	62,592	500,571	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		62,592	500,571		
H - SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	190,673	0	1.00
2.00	OPERATION OF PLANT	7.00	0	9,245	0	2.00
3.00	HOUSEKEEPING	9.00	0	14,260	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	100,457	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	765,022	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	2,772,311	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	637,594	0	7.00
8.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	412,199	0	8.00
9.00	SUBPROVIDER - IRF	41.00	0	225,036	0	9.00
10.00	NURSERY	43.00	0	29,178	0	10.00
11.00	OPERATING ROOM	50.00	0	6,049,007	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,937	0	12.00
13.00	RADIOLOGY - THERAPEUTIC	55.00	0	352	0	13.00
14.00	RADIOISOTOPE	56.00	0	577,511	0	14.00
15.00	CT SCAN	57.00	0	24,606	0	15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	22,165	0	16.00
17.00	LABORATORY	60.00	0	24,466	0	17.00
18.00	INTRAVENOUS THERAPY	64.00	0	37,714	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	1,149,993	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	252,999	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	26,350	0	21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	41,577	0	22.00
23.00	RENAL DIALYSIS	74.00	0	232,447	0	23.00
24.00	CARDIAC REHABILITATION	76.97	0	2,015	0	24.00
25.00	EMERGENCY	91.00	0	1,030,427	0	25.00
26.00	OTHER NRCC	192.01	0	1,325	0	26.00
	TOTALS		0	14,659,866		
I - IMPLANTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	206,211	0	1.00
2.00	OPERATION OF PLANT	7.00	0	7,530	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,400	0	3.00
4.00	PHARMACY	15.00	0	1,416	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,431	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	870	0	6.00
7.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	11,537	0	7.00
8.00	OPERATING ROOM	50.00	0	9,824,611	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75	0	9.00
10.00	RADIOISOTOPE	56.00	0	978,900	0	10.00
11.00	CT SCAN	57.00	0	1,427	0	11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	5,102,565	0	12.00
13.00	LABORATORY	60.00	0	3,150	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	216,288	0	14.00
15.00	EMERGENCY	91.00	0	647	0	15.00
	TOTALS		0	16,361,058		
J - REHAB						
1.00	SUBPROVIDER - IRF	41.00	0	2,051,873	0	1.00
	TOTALS		0	2,051,873		
K - PHARMA PARAMED						
1.00	PHARMACY	15.00	51,044	0	0	1.00
	TOTALS		51,044	0		
L - CAPITAL INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	820,528	12	1.00
	TOTALS		0	820,528		
500.00	Grand Total: Decreases		1,555,404	70,138,075		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 9:54 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	7,950,000	0	0	0	0	1.00	
2.00	Land Improvements	1,188,596	0	0	0	0	2.00	
3.00	Buildings and Fixtures	117,122,353	0	0	0	18,527,941	3.00	
4.00	Building Improvements	3,945,052	14,157,527	0	14,157,527	0	4.00	
5.00	Fixed Equipment	2,170,591	1,230,791	0	1,230,791	0	5.00	
6.00	Movable Equipment	26,342,842	1,779,040	0	1,779,040	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	158,719,434	17,167,358	0	17,167,358	18,527,941	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	158,719,434	17,167,358	0	17,167,358	18,527,941	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,950,000	0				1.00	
2.00	Land Improvements	1,188,596	0				2.00	
3.00	Buildings and Fixtures	98,594,412	0				3.00	
4.00	Building Improvements	18,102,579	0				4.00	
5.00	Fixed Equipment	3,401,382	0				5.00	
6.00	Movable Equipment	28,121,882	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	157,358,851	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	157,358,851	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 9:54 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	-2,427	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-2,427	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	-2,427				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	-2,427				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 9:54 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	132,376,592	0	132,376,592	0.834029	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,342,842	0	26,342,842	0.165971	0	2.00
3.00	Total (sum of lines 1-2)	158,719,434	0	158,719,434	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	8,174,459	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,063,030	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,237,489	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	-23,015	820,528	0	0	8,971,972	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,508,693	0	0	0	16,571,723	2.00
3.00	Total (sum of lines 1-2)	10,485,678	820,528	0	0	25,543,695	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 9:54 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		B	-6,031,148	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)						
4.00	Investment income - other (chapter 2)						
5.00	Trade, quantity, and time discounts (chapter 8)						
6.00	Refunds and rebates of expenses (chapter 8)						
7.00	Rental of provider space by suppliers (chapter 8)	B	-114,833	OPERATION OF PLANT	7.00	0	6.00
8.00	Telephone services (pay stations excluded) (chapter 21)						
9.00	Television and radio service (chapter 21)						
10.00	Parking lot (chapter 21)						
11.00	Provider-based physician adjustment	A-8-2	-6,702,072			0	10.00
12.00	Sale of scrap, waste, etc. (chapter 23)						
13.00	Related organization transactions (chapter 10)	A-8-1	10,772,929			0	12.00
14.00	Laundry and linen service						
15.00	Cafeteria-employees and guests	A	-805,585	CAFETERIA	11.00	0	14.00
16.00	Rental of quarters to employee and others						
17.00	Sale of medical and surgical supplies to other than patients						
18.00	Sale of drugs to other than patients						
19.00	Sale of medical records and abstracts	B	-1,911	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
20.00	Nursing and allied health education (tuition, fees, books, etc.)						
21.00	Vending machines						
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)						
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
26.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	2,808,368	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	2,779,313	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
29.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
30.00	Physicians' assistant						
31.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00		30.00
32.00	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
33.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	68.00		31.00
	CAH HIT Adjustment for Depreciation and Interest						
	MISC INCOME	B	-11,456	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME	B	-496,646	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RENTAL INCOME	B	-254,728	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC INCOME	B	-1,900	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISC INCOME	B	-8,686	PHARMACY	15.00	0	33.04
33.05	MISC INCOME	B	-41	OPERATING ROOM	50.00	0	33.05
33.06	MISC INCOME	B	-38,110	LABORATORY	60.00	0	33.06
33.07	MISC INCOME	B	-1,575	PHYSICAL THERAPY	66.00	0	33.07
33.08	MISC INCOME	B	-4,183	CARDIAC REHABILITATION	76.97	0	33.08
33.09	CONTRIBUTIONS CHARITABLE	A	-70,791	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	UTILITIES TELEVIDEO	A	-3,833	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CONFRENCING						
33.11	MARKETING	A	-275	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MARKETING		0		0.00	0	33.12
33.13	CONTRIBUTIONS CHARITABLE		0		0.00	0	33.13
33.14	CONTRIBUTIONS CHARITABLE	A	-255	CARDIAC REHABILITATION	76.97	0	33.14
33.15	PHYSICIAN PART B	A	-2,642,981	OTHER NRCC	192.01	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.16
33.17	(3)						
33.17	PATIENT INTEREST INCOME	B	-91,568	CAP REL COSTS-BLDG & FIXT	1.00	11	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.18
33.19	(3)						
33.19	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.19
33.20	(3)						
33.20	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.20
50.00	(3)						
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-921,967				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: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 9:54 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	CAP REL COSTS-BLDG & FIXT	68,553	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP REL COSTS-MVBLE EQUIP	10,508,693	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS DEPARTMENT	610,087	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	40,245,501	51,296,973	3.01
3.02	7.00	OPERATION OF PLANT	OPERATION OF PLANT	8,525,436	0	3.02
3.03	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE	28,342	0	3.03
3.04	13.00	NURSING ADMINISTRATION	NURSING ADMINISTRATION	305,687	0	3.04
3.05	15.00	PHARMACY	PHARMACY	99,196	0	3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS & LIBRARY	119,440	0	3.06
3.07	31.00	INTENSIVE CARE UNIT	INTENSIVE CARE UNIT	1,349,712	0	3.07
3.08	0.00			0	0	3.08
3.09	60.00	LABORATORY	ALVERNO	13,859,792	13,650,537	3.09
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
3.18	0.00			0	0	3.18
3.19	0.00			0	0	3.19
3.20	0.00			0	0	3.20
3.21	0.00			0	0	3.21
3.22	0.00			0	0	3.22
3.23	0.00			0	0	3.23
3.24	0.00			0	0	3.24
3.25	0.00			0	0	3.25
3.26	0.00			0	0	3.26
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			75,720,439	64,947,510	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	PRESENCE HEALTH	100.00	0.00	6.00
7.00	C	APHL LABS	66.67	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: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 9:54 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	68,553	11		1.00
2.00	10,508,693	11		2.00
3.00	610,087	0		3.00
3.01	-11,051,472	0		3.01
3.02	8,525,436	0		3.02
3.03	28,342	0		3.03
3.04	305,687	0		3.04
3.05	99,196	0		3.05
3.06	119,440	0		3.06
3.07	1,349,712	0		3.07
3.08	0	0		3.08
3.09	209,255	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
3.21	0	0		3.21
3.22	0	0		3.22
3.23	0	11		3.23
3.24	0	11		3.24
3.25	0	0		3.25
3.26	0	0		3.26
4.00	0	0		4.00
5.00	10,772,929			5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 9:54 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	16,688	0	16,688	211,500	480	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	465,624	84,992	380,632	211,500	2,789	2.00
3.00	13.00	NURSING ADMINISTRATION	38,188	38,188	0	0	0	3.00
4.00	15.00	PHARMACY	1,500	1,500	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	322,035	320,635	1,400	179,000	7	5.00
6.00	31.00	INTENSIVE CARE UNIT	958,996	958,996	0	0	0	6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	55,500	55,500	0	0	0	7.00
8.00	41.00	SUBPROVIDER - IRF	103,680	103,680	0	0	0	8.00
9.00	50.00	OPERATING ROOM	2,129,312	2,129,312	0	0	0	9.00
10.00	55.00	RADIOLOGY - THERAPEUTIC	10,800	400	10,400	271,900	108	10.00
11.00	56.00	RADIOISOTOPE	3,218	3,218	0	0	0	11.00
12.00	60.00	LABORATORY	93,200	57,200	36,000	260,300	382	12.00
13.00	64.00	INTRAVENOUS THERAPY	3,825	0	3,825	211,500	43	13.00
14.00	65.00	RESPIRATORY THERAPY	47,888	47,888	0	0	0	14.00
15.00	66.00	PHYSICAL THERAPY	17,550	0	17,550	211,500	120	15.00
16.00	69.00	ELECTROCARDIOLOGY	22,700	22,700	0	0	0	16.00
17.00	74.00	RENAL DIALYSIS	21,000	21,000	0	0	0	17.00
18.00	76.10	OUTPATIENT PSYCH	64,600	64,600	0	0	0	18.00
19.00	91.00	EMERGENCY	2,734,835	2,683,648	51,187	211,500	450	19.00
200.00			7,111,139	6,593,457	517,682		4,379	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 9:54 am

	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	48,808	2,440	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	283,593	14,180	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	15.00	PHARMACY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	602	30	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	55.00	RADIOLOGY - THERAPEUTIC	14,118	706	0	0	0	10.00
11.00	56.00	RADIOISOTOPE	0	0	0	0	0	11.00
12.00	60.00	LABORATORY	47,805	2,390	0	0	0	12.00
13.00	64.00	INTRAVENOUS THERAPY	4,372	219	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	14.00
15.00	66.00	PHYSICAL THERAPY	12,202	610	0	0	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	16.00
17.00	74.00	RENAL DIALYSIS	0	0	0	0	0	17.00
18.00	76.10	OUTPATIENT PSYCH	0	0	0	0	0	18.00
19.00	91.00	EMERGENCY	45,757	2,288	0	0	0	19.00
200.00			457,257	22,863	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 9:54 am

	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	48,808	0	0		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	283,593	97,039	182,031		2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	38,188		3.00
4.00	15.00	PHARMACY	0	0	0	1,500		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	602	798	321,433		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	958,996		6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	55,500		7.00
8.00	41.00	SUBPROVIDER - IRF	0	0	0	103,680		8.00
9.00	50.00	OPERATING ROOM	0	0	0	2,129,312		9.00
10.00	55.00	RADIOLOGY - THERAPEUTIC	0	14,118	0	400		10.00
11.00	56.00	RADIOISOTOPE	0	0	0	3,218		11.00
12.00	60.00	LABORATORY	0	47,805	0	57,200		12.00
13.00	64.00	INTRAVENOUS THERAPY	0	4,372	0	0		13.00
14.00	65.00	RESPIRATORY THERAPY	0	0	0	47,888		14.00
15.00	66.00	PHYSICAL THERAPY	0	12,202	5,348	5,348		15.00
16.00	69.00	ELECTROCARDIOLOGY	0	0	0	22,700		16.00
17.00	74.00	RENAL DIALYSIS	0	0	0	21,000		17.00
18.00	76.10	OUTPATIENT PSYCH	0	0	0	64,600		18.00
19.00	91.00	EMERGENCY	0	45,757	5,430	2,689,078		19.00
200.00			0	457,257	108,615	6,702,072		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	8,971,972	8,971,972			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,571,723		16,571,723		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,134,561	0	0	16,134,561	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	91,070,239	2,343,957	544,786	684,950	94,643,932
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	19,135,320	1,737,618	502,559	186,048	21,561,545
8.00	00800	LAUNDRY & LINEN SERVICE	801,539	0	0	0	801,539
9.00	00900	HOUSEKEEPING	4,968,611	226,657	33,750	0	5,229,018
10.00	01000	DIETARY	2,966,846	91,280	37,505	0	3,095,631
11.00	01100	CAFETERIA	2,887,337	113,657	46,699	0	3,047,693
13.00	01300	NURSING ADMINISTRATION	11,192,462	0	1,146,624	614,933	12,954,019
14.00	01400	CENTRAL SERVICES & SUPPLY	573,323	0	17,529	0	590,852
15.00	01500	PHARMACY	4,932,720	37,377	0	667,347	5,637,444
16.00	01600	MEDICAL RECORDS & LIBRARY	117,529	60,523	11,021	0	189,073
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	62,592	0	0	11,224	73,816
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	500,571	0	0	0	500,571
23.00	02300	PARAMED ED PRGM-(SPECIFY)	236,790	2,222	0	39,249	278,261
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,984,491	1,980,126	121,184	5,715,162	45,800,963
31.00	03100	INTENSIVE CARE UNIT	5,476,310	192,123	155,966	597,884	6,422,283
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,995,135	180,430	13,041	853,377	7,041,983
41.00	04100	SUBPROVIDER - IRF	5,371,634	155,617	16,028	695,973	6,239,252
43.00	04300	NURSERY	1,578,776	179,874	203,291	246,361	2,208,302
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,119,118	392,764	3,947,127	1,605,487	26,064,496
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,191,172	61,180	68,049	185,877	1,506,278
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,271,193	153,154	3,844,837	570,736	8,839,920
55.00	05500	RADIOLOGY - THERAPEUTIC	172,065	82,012	23,009	9	277,095
56.00	05600	RADIOISOTOPE	3,586,649	66,300	1,622,171	268,223	5,543,343
57.00	05700	CT SCAN	1,136,304	23,396	937,614	166,049	2,263,363
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	719,561	27,563	143,032	93,784	983,940
59.00	05900	CARDIAC CATHETERIZATION	7,565,768	103,103	826,535	499,902	8,995,308
60.00	06000	LABORATORY	15,070,592	78,234	882,825	0	16,031,651
64.00	06400	INTRAVENOUS THERAPY	698,080	0	0	114,764	812,844
65.00	06500	RESPIRATORY THERAPY	3,116,640	21,183	342,568	467,395	3,947,786
66.00	06600	PHYSICAL THERAPY	10,384,281	190,994	73,355	30,109	10,678,739
69.00	06900	ELECTROCARDIOLOGY	977,474	126,017	518,846	160,761	1,783,098
70.00	07000	ELECTROENCEPHALOGRAPHY	259,130	0	20,363	36,618	316,111
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,417,039	0	0	0	14,417,039
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,361,058	0	0	0	16,361,058
73.00	07300	DRUGS CHARGED TO PATIENTS	17,063,093	0	0	0	17,063,093
74.00	07400	RENAL DIALYSIS	1,044,075	36,997	195,638	128,130	1,404,840
76.00	03950	OTHER ANCILLARY	0	0	0	0	0
76.10	03550	OUTPATIENT PSYCH	80,148	0	0	12,388	92,536
76.97	07697	CARDIAC REHABILITATION	281,771	0	60,294	47,462	389,527
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	8,555,642	299,068	167,684	1,381,430	10,403,824
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	364,601,334	8,963,426	16,523,930	16,081,632	364,492,066
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	1,651,237	8,546	47,793	52,929	1,760,505
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	366,252,571	8,971,972	16,571,723	16,134,561	366,252,571

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	94,643,932					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	7,513,271	0	29,074,816			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	279,302	0	0	1,080,841		8.00
9.00	00900	HOUSEKEEPING	1,822,088	0	1,347,544	0	8,398,650	9.00
10.00	01000	DIETARY	1,078,694	0	542,683	0	164,380	10.00
11.00	01100	CAFETERIA	1,061,990	0	675,726	0	204,679	11.00
13.00	01300	NURSING ADMINISTRATION	4,513,919	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	205,887	0	0	0	0	14.00
15.00	01500	PHARMACY	1,964,407	0	222,215	0	67,309	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,884	0	359,826	0	108,992	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	25,722	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	174,427	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	96,962	0	13,211	0	4,002	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,959,668	0	11,772,413	788,887	3,565,889	30.00
31.00	03100	INTENSIVE CARE UNIT	2,237,889	0	1,142,228	49,114	345,983	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,453,828	0	1,072,707	76,457	324,925	34.00
41.00	04100	SUBPROVIDER - IRF	2,174,111	0	925,187	147,855	280,241	41.00
43.00	04300	NURSERY	769,498	0	1,069,404	18,528	323,925	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,082,356	0	2,335,096	0	707,306	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	524,873	0	363,734	0	110,176	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,080,332	0	910,546	0	275,806	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	96,556	0	487,584	0	147,690	55.00
56.00	05600	RADIOISOTOPE	1,931,617	0	394,173	0	119,396	56.00
57.00	05700	CT SCAN	788,685	0	139,097	0	42,133	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	342,861	0	163,867	0	49,636	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,134,478	0	612,975	0	185,671	59.00
60.00	06000	LABORATORY	5,586,341	0	465,126	0	140,888	60.00
64.00	06400	INTRAVENOUS THERAPY	283,241	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,375,634	0	125,942	0	38,148	65.00
66.00	06600	PHYSICAL THERAPY	3,721,081	0	1,135,512	0	343,949	66.00
69.00	06900	ELECTROCARDIOLOGY	621,333	0	749,210	0	226,937	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	110,151	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,023,718	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,701,125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,945,754	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	489,526	0	219,958	0	66,626	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	32,245	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	135,733	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,625,285	0	1,778,046	0	538,574	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)	94,030,472	0	29,024,010	1,080,841	8,383,261	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	613,460	0	50,806	0	15,389	192.01
200.00		Cross Foot Adjustments		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)	94,643,932	0	29,074,816	1,080,841	8,398,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

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
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	4,881,388					10.00
11.00	01100	CAFETERIA	0	4,990,088				11.00
13.00	01300	NURSING ADMINISTRATION	0	199,858	17,667,796			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	796,739		14.00
15.00	01500	PHARMACY	0	216,920	0	0	8,108,295	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	32,829	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	12,732	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,858,322	1,857,533	8,373,129	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	119,275	194,307	1,019,181	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	185,684	277,359	1,473,437	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	718,107	226,210	1,018,921	0	0	41.00
43.00	04300	NURSERY	0	80,054	347,422	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	521,815	1,719,934	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	60,402	262,132	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	169,546	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	171,558	0	0	55.00
56.00	05600	RADIOISOTOPE	0	95,266	0	0	0	56.00
57.00	05700	CT SCAN	0	58,995	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	33,310	15	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	162,477	549,930	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	37,307	198,416	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	151,929	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,771	50,295	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	52,259	90,512	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,917	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	373,214	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	423,525	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,108,295	73.00
74.00	07400	RENAL DIALYSIS	0	41,637	209,760	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	4,034	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	15,433	22,766	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	448,978	1,993,853	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)	4,881,388	4,972,878	17,501,261	796,739	8,108,295	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	17,210	166,535	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,881,388	4,990,088	17,667,796	796,739	8,108,295	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	723,775					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	132,367			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		674,998		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			405,168	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	98,966	0	101,700	518,615	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,501	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	17,855	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	12,251	0	0	0	0	41.00
43.00	04300	NURSERY	2,448	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	68,433	0	30,667	156,383	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,421	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,966	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	58	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	15,579	0	0	0	0	56.00
57.00	05700	CT SCAN	44,963	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,567	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,630	0	0	0	0	59.00
60.00	06000	LABORATORY	85,033	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,889	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,274	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	34,920	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	17,252	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,787	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,274	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,930	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,104	0	0	0	405,168	73.00
74.00	07400	RENAL DIALYSIS	2,875	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	504	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	854	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	66,441	0	0	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)	723,775	0	132,367	674,998	405,168	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
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)	723,775	0	132,367	674,998	405,168	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,696,085	-620,315	92,075,770	30.00
31.00	03100	INTENSIVE CARE UNIT	11,542,761	0	11,542,761	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	12,924,235	0	12,924,235	34.00
41.00	04100	SUBPROVIDER - IRF	11,742,135	0	11,742,135	41.00
43.00	04300	NURSERY	4,819,581	0	4,819,581	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,686,486	-187,050	40,499,436	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,831,016	0	2,831,016	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,310,116	0	13,310,116	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,180,541	0	1,180,541	55.00
56.00	05600	RADIOISOTOPE	8,099,374	0	8,099,374	56.00
57.00	05700	CT SCAN	3,337,236	0	3,337,236	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,587,196	0	1,587,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,681,469	0	13,681,469	59.00
60.00	06000	LABORATORY	22,309,039	0	22,309,039	60.00
64.00	06400	INTRAVENOUS THERAPY	1,334,697	0	1,334,697	64.00
65.00	06500	RESPIRATORY THERAPY	5,653,713	0	5,653,713	65.00
66.00	06600	PHYSICAL THERAPY	15,974,267	0	15,974,267	66.00
69.00	06900	ELECTROCARDIOLOGY	3,540,601	0	3,540,601	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	439,966	0	439,966	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,862,245	0	19,862,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,526,638	0	22,526,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,565,414	0	31,565,414	73.00
74.00	07400	RENAL DIALYSIS	2,435,222	0	2,435,222	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	129,319	0	129,319	76.10
76.97	07697	CARDIAC REHABILITATION	564,313	0	564,313	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	18,855,001	0	18,855,001	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)	363,628,666	-807,365	362,821,301	118.00
NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	2,623,905	0	2,623,905	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	366,252,571	-807,365	365,445,206	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,343,957	544,786	2,888,743	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,737,618	502,559	2,240,177	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	226,657	33,750	260,407	9.00
10.00	01000	DIETARY	0	91,280	37,505	128,785	10.00
11.00	01100	CAFETERIA	0	113,657	46,699	160,356	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,146,624	1,146,624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	17,529	17,529	14.00
15.00	01500	PHARMACY	0	37,377	0	37,377	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,523	11,021	71,544	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	2,222	0	2,222	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,980,126	121,184	2,101,310	30.00
31.00	03100	INTENSIVE CARE UNIT	0	192,123	155,966	348,089	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	180,430	13,041	193,471	34.00
41.00	04100	SUBPROVIDER - IRF	0	155,617	16,028	171,645	41.00
43.00	04300	NURSERY	0	179,874	203,291	383,165	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	392,764	3,947,127	4,339,891	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	61,180	68,049	129,229	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	153,154	3,844,837	3,997,991	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	82,012	23,009	105,021	55.00
56.00	05600	RADIOISOTOPE	0	66,300	1,622,171	1,688,471	56.00
57.00	05700	CT SCAN	0	23,396	937,614	961,010	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	27,563	143,032	170,595	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	103,103	826,535	929,638	59.00
60.00	06000	LABORATORY	0	78,234	882,825	961,059	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	21,183	342,568	363,751	65.00
66.00	06600	PHYSICAL THERAPY	0	190,994	73,355	264,349	66.00
69.00	06900	ELECTROCARDIOLOGY	0	126,017	518,846	644,863	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	20,363	20,363	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	36,997	195,638	232,635	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	60,294	60,294	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	299,068	167,684	466,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	8,963,426	16,523,930	25,487,356	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	8,546	47,793	56,339	192.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	8,971,972	16,571,723	25,543,695	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,888,743					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	229,329	0	2,469,506			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,525	0	0	8,525		8.00
9.00	00900	HOUSEKEEPING	55,616	0	114,455	0	430,478	9.00
10.00	01000	DIETARY	32,925	0	46,093	0	8,425	10.00
11.00	01100	CAFETERIA	32,415	0	57,394	0	10,491	11.00
13.00	01300	NURSING ADMINISTRATION	137,779	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,284	0	0	0	0	14.00
15.00	01500	PHARMACY	59,960	0	18,874	0	3,450	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,011	0	30,562	0	5,586	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	785	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,324	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	2,960	0	1,122	0	205	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	487,052	0	999,906	6,223	182,772	30.00
31.00	03100	INTENSIVE CARE UNIT	68,307	0	97,017	387	17,734	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	74,899	0	91,112	603	16,654	34.00
41.00	04100	SUBPROVIDER - IRF	66,361	0	78,582	1,166	14,364	41.00
43.00	04300	NURSERY	23,488	0	90,831	146	16,603	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	277,222	0	198,334	0	36,253	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,021	0	30,894	0	5,647	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,021	0	77,338	0	14,137	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,947	0	41,414	0	7,570	55.00
56.00	05600	RADIOISOTOPE	58,959	0	33,480	0	6,120	56.00
57.00	05700	CT SCAN	24,073	0	11,814	0	2,160	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,465	0	13,918	0	2,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	95,674	0	52,064	0	9,517	59.00
60.00	06000	LABORATORY	170,513	0	39,506	0	7,221	60.00
64.00	06400	INTRAVENOUS THERAPY	8,645	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	41,989	0	10,697	0	1,955	65.00
66.00	06600	PHYSICAL THERAPY	113,579	0	96,446	0	17,629	66.00
69.00	06900	ELECTROCARDIOLOGY	18,965	0	63,635	0	11,632	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,362	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,340	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	174,016	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,483	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	14,942	0	18,682	0	3,415	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	984	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	4,143	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	110,655	0	151,021	0	27,605	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)	2,870,018	0	2,465,191	8,525	429,689	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	18,725	0	4,315	0	789	192.01
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)	2,888,743	0	2,469,506	8,525	430,478	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	216,228					10.00
11.00	01100	CAFETERIA	0	260,656				11.00
13.00	01300	NURSING ADMINISTRATION	0	10,440	1,294,843			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	23,813		14.00
15.00	01500	PHARMACY	0	11,331	0	0	130,992	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,715	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	665	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	170,910	97,025	613,653	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,283	10,150	74,694	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,225	14,488	107,986	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	31,810	11,816	74,675	0	0	41.00
43.00	04300	NURSERY	0	4,182	25,462	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,257	126,051	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,155	19,211	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,856	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	12,573	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,976	0	0	0	56.00
57.00	05700	CT SCAN	0	3,082	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,740	1	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,487	40,303	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,949	14,542	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,936	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	510	3,686	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,730	6,634	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	623	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,159	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,654	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	130,992	73.00
74.00	07400	RENAL DIALYSIS	0	2,175	15,373	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	211	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	806	1,668	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	23,452	146,126	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)	216,228	259,757	1,282,638	23,813	130,992	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	899	12,205	0	0	192.01
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)	216,228	260,656	1,294,843	23,813	130,992	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER		
					APPRV	PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,703					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,500			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		5,324		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			7,174	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,457	0				30.00
31.00	03100	INTENSIVE CARE UNIT	1,886	0				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,693	0				34.00
41.00	04100	SUBPROVIDER - IRF	1,848	0				41.00
43.00	04300	NURSERY	369	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,322	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	516	0				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,123	0				54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	9	0				55.00
56.00	05600	RADIOISOTOPE	2,350	0				56.00
57.00	05700	CT SCAN	6,782	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,046	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	6,129	0				59.00
60.00	06000	LABORATORY	12,826	0				60.00
64.00	06400	INTRAVENOUS THERAPY	436	0				64.00
65.00	06500	RESPIRATORY THERAPY	2,153	0				65.00
66.00	06600	PHYSICAL THERAPY	5,267	0				66.00
69.00	06900	ELECTROCARDIOLOGY	2,602	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,282	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,174	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,502	0				73.00
74.00	07400	RENAL DIALYSIS	434	0				74.00
76.00	03950	OTHER ANCILLARY	0	0				76.00
76.10	03550	OUTPATIENT PSYCH	76	0				76.10
76.97	07697	CARDIAC REHABILITATION	129	0				76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10,022	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)	109,703	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0				192.01
200.00		Cross Foot Adjustments			2,500	5,324	7,174	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,703	0	2,500	5,324	7,174	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,674,308	0	4,674,308	30.00
31.00	03100	INTENSIVE CARE UNIT	623,547	0	623,547	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	510,131	0	510,131	34.00
41.00	04100	SUBPROVIDER - IRF	452,267	0	452,267	41.00
43.00	04300	NURSERY	544,246	0	544,246	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,015,330	0	5,015,330	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,673	0	204,673	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,197,466	0	4,197,466	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	169,534	0	169,534	55.00
56.00	05600	RADIOISOTOPE	1,794,356	0	1,794,356	56.00
57.00	05700	CT SCAN	1,008,921	0	1,008,921	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	201,309	0	201,309	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,141,812	0	1,141,812	59.00
60.00	06000	LABORATORY	1,191,125	0	1,191,125	60.00
64.00	06400	INTRAVENOUS THERAPY	25,572	0	25,572	64.00
65.00	06500	RESPIRATORY THERAPY	428,481	0	428,481	65.00
66.00	06600	PHYSICAL THERAPY	501,466	0	501,466	66.00
69.00	06900	ELECTROCARDIOLOGY	751,061	0	751,061	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,618	0	24,618	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,781	0	171,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,844	0	192,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,977	0	318,977	73.00
74.00	07400	RENAL DIALYSIS	287,656	0	287,656	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	1,271	0	1,271	76.10
76.97	07697	CARDIAC REHABILITATION	67,040	0	67,040	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	935,633	0	935,633	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)	25,435,425	0	25,435,425	118.00
NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	93,272	0	93,272	192.01
200.00		Cross Foot Adjustments	14,998	0	14,998	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,543,695	0	25,543,695	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	969,052					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,256,941				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	89,978,496			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	253,168	107,070	3,819,794	-94,643,932	271,608,639	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	187,678	98,771	1,037,545	0	21,561,545	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	801,539	8.00
9.00	00900	HOUSEKEEPING	24,481	6,633	0	0	5,229,018	9.00
10.00	01000	DIETARY	9,859	7,371	0	0	3,095,631	10.00
11.00	01100	CAFETERIA	12,276	9,178	0	0	3,047,693	11.00
13.00	01300	NURSING ADMINISTRATION	0	225,353	3,429,325	0	12,954,019	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,445	0	0	590,852	14.00
15.00	01500	PHARMACY	4,037	0	3,721,624	0	5,637,444	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,537	2,166	0	0	189,073	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	62,592	0	73,816	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	500,571	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	240	0	218,880	0	278,261	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	213,871	23,817	31,872,160	0	45,800,963	30.00
31.00	03100	INTENSIVE CARE UNIT	20,751	30,653	3,334,247	0	6,422,283	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	19,488	2,563	4,759,070	0	7,041,983	34.00
41.00	04100	SUBPROVIDER - IRF	16,808	3,150	3,881,263	0	6,239,252	41.00
43.00	04300	NURSERY	19,428	39,954	1,373,892	0	2,208,302	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,422	775,753	8,953,396	0	26,064,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,608	13,374	1,036,590	0	1,506,278	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,542	755,649	3,182,848	0	8,839,920	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	8,858	4,522	50	0	277,095	55.00
56.00	05600	RADIOISOTOPE	7,161	318,815	1,495,811	0	5,543,343	56.00
57.00	05700	CT SCAN	2,527	184,275	926,011	0	2,263,363	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,977	28,111	523,010	0	983,940	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,136	162,444	2,787,828	0	8,995,308	59.00
60.00	06000	LABORATORY	8,450	173,507	0	0	16,031,651	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	640,008	0	812,844	64.00
65.00	06500	RESPIRATORY THERAPY	2,288	67,327	2,606,542	0	3,947,786	65.00
66.00	06600	PHYSICAL THERAPY	20,629	14,417	167,908	0	10,678,739	66.00
69.00	06900	ELECTROCARDIOLOGY	13,611	101,972	896,521	0	1,783,098	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,002	204,211	0	316,111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,417,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	16,361,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	17,063,093	73.00
74.00	07400	RENAL DIALYSIS	3,996	38,450	714,547	0	1,404,840	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	69,084	0	92,536	76.10
76.97	07697	CARDIAC REHABILITATION	0	11,850	264,681	0	389,527	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	32,302	32,956	7,703,886	0	10,403,824	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)	968,129	3,247,548	89,683,324	-94,643,932	269,848,134	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	923	9,393	295,172	0	1,760,505	192.01
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)	8,971,972	16,571,723	16,134,561		94,643,932	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.258504	5.088125	0.179316		0.348457	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		2,888,743	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.010636	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: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	528,206			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	82,020		8.00
9.00	00900	HOUSEKEEPING	0	24,481	0	503,725	9.00
10.00	01000	DIETARY	0	9,859	0	9,859	190,672 10.00
11.00	01100	CAFETERIA	0	12,276	0	12,276	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00	01500	PHARMACY	0	4,037	0	4,037	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,537	0	6,537	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	240	0	240	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	213,871	59,865	213,871	150,710 30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,751	3,727	20,751	4,659 31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	19,488	5,802	19,488	7,253 34.00
41.00	04100	SUBPROVIDER - IRF	0	16,808	11,220	16,808	28,050 41.00
43.00	04300	NURSERY	0	19,428	1,406	19,428	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	42,422	0	42,422	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,608	0	6,608	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,542	0	16,542	0 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	8,858	0	8,858	0 55.00
56.00	05600	RADIOISOTOPE	0	7,161	0	7,161	0 56.00
57.00	05700	CT SCAN	0	2,527	0	2,527	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,977	0	2,977	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,136	0	11,136	0 59.00
60.00	06000	LABORATORY	0	8,450	0	8,450	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	2,288	0	2,288	0 65.00
66.00	06600	PHYSICAL THERAPY	0	20,629	0	20,629	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,611	0	13,611	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	3,996	0	3,996	0 74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0 76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0 76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	32,302	0	32,302	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	527,283	82,020	502,802	190,672 118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	923	0	923	0 192.01
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)	0	29,074,816	1,080,841	8,398,650	4,881,388 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	55.044464	13.177774	16.673086	25.600969 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,469,506	8,525	430,478	216,228 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.675271	0.103938	0.854589	1.134031 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: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	134,828					11.00
13.00	01300	NURSING ADMINISTRATION	5,400	1,157,131				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	30,778,097			14.00
15.00	01500	PHARMACY	5,861	0	0	17,063,090		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,021,859,470	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	887	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	344	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	50,189	548,388	0	0	276,582,547	30.00
31.00	03100	INTENSIVE CARE UNIT	5,250	66,750	0	0	34,918,222	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,494	96,501	0	0	49,873,548	34.00
41.00	04100	SUBPROVIDER - IRF	6,112	66,733	0	0	34,221,724	41.00
43.00	04300	NURSERY	2,163	22,754	0	0	6,837,531	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,099	112,645	0	0	191,152,700	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,632	17,168	0	0	9,555,059	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,581	0	0	0	94,878,162	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	11,236	0	0	161,809	55.00
56.00	05600	RADIOISOTOPE	2,574	0	0	0	43,515,411	56.00
57.00	05700	CT SCAN	1,594	0	0	0	125,595,026	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	900	1	0	0	37,895,931	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,390	36,017	0	0	113,491,817	59.00
60.00	06000	LABORATORY	0	0	0	0	237,522,353	60.00
64.00	06400	INTRAVENOUS THERAPY	1,008	12,995	0	0	8,070,502	64.00
65.00	06500	RESPIRATORY THERAPY	4,105	0	0	0	39,872,350	65.00
66.00	06600	PHYSICAL THERAPY	264	3,294	0	0	97,540,844	66.00
69.00	06900	ELECTROCARDIOLOGY	1,412	5,928	0	0	48,190,234	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	322	0	0	0	4,992,439	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,417,039	0	134,843,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,361,058	0	114,330,713	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,063,090	120,402,539	73.00
74.00	07400	RENAL DIALYSIS	1,125	13,738	0	0	8,030,785	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	109	0	0	0	1,408,188	76.10
76.97	07697	CARDIAC REHABILITATION	417	1,491	0	0	2,385,416	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	12,131	130,585	0	0	185,590,392	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)	134,363	1,146,224	30,778,097	17,063,090	2,021,859,470	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	465	10,907	0	0	0	192.01
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)	4,990,088	17,667,796	796,739	8,108,295	723,775	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.010769	15.268622	0.025887	0.475195	0.000358	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	260,656	1,294,843	23,813	130,992	109,703	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.933248	1.119012	0.000774	0.007677	0.000054	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: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description		INTERNS & RESIDENTS			PARAMED ED PRGM (ASSIGNED TIME)		
		SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR	SERVICES-OTHER			
			Y & FRINGES APPRV (ASSIGNED TIME)	PRGM COSTS APPRV (ASSIGNED TIME)			
		17.00	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,230			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		4,230		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,250	3,250	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	980	980	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	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)	0	4,230	4,230	100	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	0	0	0	192.01
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)	0	132,367	674,998	405,168	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	31.292435	159.573995	4,051.680000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,500	5,324	7,174	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.591017	1.258629	71.740000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:54 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,075,770		92,075,770	798	92,076,568	30.00
31.00	03100	INTENSIVE CARE UNIT	11,542,761		11,542,761	0	11,542,761	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	12,924,235		12,924,235	0	12,924,235	34.00
41.00	04100	SUBPROVIDER - IRF	11,742,135		11,742,135	0	11,742,135	41.00
43.00	04300	NURSERY	4,819,581		4,819,581	0	4,819,581	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,499,436		40,499,436	0	40,499,436	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,831,016		2,831,016	0	2,831,016	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,310,116		13,310,116	0	13,310,116	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,180,541		1,180,541	0	1,180,541	55.00
56.00	05600	RADIOISOTOPE	8,099,374		8,099,374	0	8,099,374	56.00
57.00	05700	CT SCAN	3,337,236		3,337,236	0	3,337,236	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,587,196		1,587,196	0	1,587,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,681,469		13,681,469	0	13,681,469	59.00
60.00	06000	LABORATORY	22,309,039		22,309,039	0	22,309,039	60.00
64.00	06400	INTRAVENOUS THERAPY	1,334,697		1,334,697	0	1,334,697	64.00
65.00	06500	RESPIRATORY THERAPY	5,653,713	0	5,653,713	0	5,653,713	65.00
66.00	06600	PHYSICAL THERAPY	15,974,267	0	15,974,267	5,348	15,979,615	66.00
69.00	06900	ELECTROCARDIOLOGY	3,540,601		3,540,601	0	3,540,601	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	439,966		439,966	0	439,966	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,862,245		19,862,245	0	19,862,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,526,638		22,526,638	0	22,526,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,565,414		31,565,414	0	31,565,414	73.00
74.00	07400	RENAL DIALYSIS	2,435,222		2,435,222	0	2,435,222	74.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	129,319		129,319	0	129,319	76.10
76.97	07697	CARDIAC REHABILITATION	564,313		564,313	0	564,313	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	18,855,001		18,855,001	5,430	18,860,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,031,508		14,031,508		14,031,508	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	376,852,809	0	376,852,809	11,576	376,864,385	200.00
201.00		Less Observation Beds	14,031,508		14,031,508		14,031,508	201.00
202.00		Total (see instructions)	362,821,301	0	362,821,301	11,576	362,832,877	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:54 am

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	208,471,011		208,471,011		30.00
31.00	03100	INTENSIVE CARE UNIT	34,918,222		34,918,222		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	49,873,548		49,873,548		34.00
41.00	04100	SUBPROVIDER - IRF	34,221,724		34,221,724		41.00
43.00	04300	NURSERY	6,837,531		6,837,531		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,895,013	112,257,687	191,152,700	0.211870	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,555,059	0	9,555,059	0.296285	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,942,341	73,935,821	94,878,162	0.140286	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	147,216	14,593	161,809	7.295892	0.000000
56.00	05600	RADIOISOTOPE	20,290,901	23,224,510	43,515,411	0.186127	0.000000
57.00	05700	CT SCAN	48,481,065	77,113,961	125,595,026	0.026571	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,094,670	24,801,261	37,895,931	0.041883	0.000000
59.00	05900	CARDIAC CATHETERIZATION	40,083,364	73,408,453	113,491,817	0.120550	0.000000
60.00	06000	LABORATORY	124,828,936	112,693,417	237,522,353	0.093924	0.000000
64.00	06400	INTRAVENOUS THERAPY	48,615	8,021,887	8,070,502	0.165380	0.000000
65.00	06500	RESPIRATORY THERAPY	32,243,151	7,629,199	39,872,350	0.141795	0.000000
66.00	06600	PHYSICAL THERAPY	39,473,159	58,067,685	97,540,844	0.163770	0.000000
69.00	06900	ELECTROCARDIOLOGY	24,382,840	23,807,394	48,190,234	0.073471	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	1,092,983	3,899,456	4,992,439	0.088126	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,601,832	69,241,396	134,843,228	0.147299	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,663,097	44,667,616	114,330,713	0.197031	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	74,251,294	46,151,245	120,402,539	0.262166	0.000000
74.00	07400	RENAL DIALYSIS	7,469,312	561,473	8,030,785	0.303236	0.000000
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000
76.10	03550	OUTPATIENT PSYCH	1,401,776	6,412	1,408,188	0.091834	0.000000
76.97	07697	CARDIAC REHABILITATION	8,467	2,376,949	2,385,416	0.236568	0.000000
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	65,083,316	120,507,076	185,590,392	0.101595	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,245,210	58,866,326	68,111,536	0.206008	0.000000
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,080,605,653	941,253,817	2,021,859,470		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,080,605,653	941,253,817	2,021,859,470		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.211870		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296285		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140286		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	7.295892		55.00
56.00	05600	RADIOISOTOPE	0.186127		56.00
57.00	05700	CT SCAN	0.026571		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041883		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.120550		59.00
60.00	06000	LABORATORY	0.093924		60.00
64.00	06400	INTRAVENOUS THERAPY	0.165380		64.00
65.00	06500	RESPIRATORY THERAPY	0.141795		65.00
66.00	06600	PHYSICAL THERAPY	0.163825		66.00
69.00	06900	ELECTROCARDIOLOGY	0.073471		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.088126		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147299		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.197031		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262166		73.00
74.00	07400	RENAL DIALYSIS	0.303236		74.00
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.10	03550	OUTPATIENT PSYCH	0.091834		76.10
76.97	07697	CARDIAC REHABILITATION	0.236568		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.101624		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.206008		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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:54 am

				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	92,075,770		92,075,770	798	92,076,568	30.00	
31.00	03100	INTENSIVE CARE UNIT	11,542,761		11,542,761	0	11,542,761	31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	12,924,235		12,924,235	0	12,924,235	34.00	
41.00	04100	SUBPROVIDER - IRF	11,742,135		11,742,135	0	11,742,135	41.00	
43.00	04300	NURSERY	4,819,581		4,819,581	0	4,819,581	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	40,499,436		40,499,436	0	40,499,436	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,831,016		2,831,016	0	2,831,016	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,310,116		13,310,116	0	13,310,116	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	1,180,541		1,180,541	0	1,180,541	55.00	
56.00	05600	RADIOISOTOPE	8,099,374		8,099,374	0	8,099,374	56.00	
57.00	05700	CT SCAN	3,337,236		3,337,236	0	3,337,236	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,587,196		1,587,196	0	1,587,196	58.00	
59.00	05900	CARDIAC CATHETERIZATION	13,681,469		13,681,469	0	13,681,469	59.00	
60.00	06000	LABORATORY	22,309,039		22,309,039	0	22,309,039	60.00	
64.00	06400	INTRAVENOUS THERAPY	1,334,697		1,334,697	0	1,334,697	64.00	
65.00	06500	RESPIRATORY THERAPY	5,653,713	0	5,653,713	0	5,653,713	65.00	
66.00	06600	PHYSICAL THERAPY	15,974,267	0	15,974,267	5,348	15,979,615	66.00	
69.00	06900	ELECTROCARDIOLOGY	3,540,601		3,540,601	0	3,540,601	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	439,966		439,966	0	439,966	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,862,245		19,862,245	0	19,862,245	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,526,638		22,526,638	0	22,526,638	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	31,565,414		31,565,414	0	31,565,414	73.00	
74.00	07400	RENAL DIALYSIS	2,435,222		2,435,222	0	2,435,222	74.00	
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00	
76.10	03550	OUTPATIENT PSYCH	129,319		129,319	0	129,319	76.10	
76.97	07697	CARDIAC REHABILITATION	564,313		564,313	0	564,313	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	18,855,001		18,855,001	5,430	18,860,431	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,031,508		14,031,508		14,031,508	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	376,852,809	0	376,852,809	11,576	376,864,385	200.00	
201.00		Less Observation Beds	14,031,508		14,031,508		14,031,508	201.00	
202.00		Total (see instructions)	362,821,301	0	362,821,301	11,576	362,832,877	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0007		Period: From 07/01/2020 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/29/2021 9:54 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	208,471,011		208,471,011				30.00	
31.00	03100	INTENSIVE CARE UNIT	34,918,222		34,918,222				31.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	49,873,548		49,873,548				34.00	
41.00	04100	SUBPROVIDER - IRF	34,221,724		34,221,724				41.00	
43.00	04300	NURSERY	6,837,531		6,837,531				43.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	78,895,013	112,257,687	191,152,700	0.211870	0.000000		50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,555,059	0	9,555,059	0.296285	0.000000		52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,942,341	73,935,821	94,878,162	0.140286	0.000000		54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	147,216	14,593	161,809	7.295892	0.000000		55.00	
56.00	05600	RADIOISOTOPE	20,290,901	23,224,510	43,515,411	0.186127	0.000000		56.00	
57.00	05700	CT SCAN	48,481,065	77,113,961	125,595,026	0.026571	0.000000		57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,094,670	24,801,261	37,895,931	0.041883	0.000000		58.00	
59.00	05900	CARDIAC CATHETERIZATION	40,083,364	73,408,453	113,491,817	0.120550	0.000000		59.00	
60.00	06000	LABORATORY	124,828,936	112,693,417	237,522,353	0.093924	0.000000		60.00	
64.00	06400	INTRAVENOUS THERAPY	48,615	8,021,887	8,070,502	0.165380	0.000000		64.00	
65.00	06500	RESPIRATORY THERAPY	32,243,151	7,629,199	39,872,350	0.141795	0.000000		65.00	
66.00	06600	PHYSICAL THERAPY	39,473,159	58,067,685	97,540,844	0.163770	0.000000		66.00	
69.00	06900	ELECTROCARDIOLOGY	24,382,840	23,807,394	48,190,234	0.073471	0.000000		69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	1,092,983	3,899,456	4,992,439	0.088126	0.000000		70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,601,832	69,241,396	134,843,228	0.147299	0.000000		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,663,097	44,667,616	114,330,713	0.197031	0.000000		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	74,251,294	46,151,245	120,402,539	0.262166	0.000000		73.00	
74.00	07400	RENAL DIALYSIS	7,469,312	561,473	8,030,785	0.303236	0.000000		74.00	
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000		76.00	
76.10	03550	OUTPATIENT PSYCH	1,401,776	6,412	1,408,188	0.091834	0.000000		76.10	
76.97	07697	CARDIAC REHABILITATION	8,467	2,376,949	2,385,416	0.236568	0.000000		76.97	
OUTPATIENT SERVICE COST CENTERS										
91.00	09100	EMERGENCY	65,083,316	120,507,076	185,590,392	0.101595	0.000000		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,245,210	58,866,326	68,111,536	0.206008	0.000000		92.00	
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE							113.00	
200.00		Subtotal (see instructions)	1,080,605,653	941,253,817	2,021,859,470				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	1,080,605,653	941,253,817	2,021,859,470				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
41.00	04100	SUBPROVIDER - IRF				41.00
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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03950	OTHER ANCILLARY	0.000000			76.00
76.10	03550	OUTPATIENT PSYCH	0.000000			76.10
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 9:54 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,674,308	0	4,674,308	70,628	66.18	30.00
31.00	INTENSIVE CARE UNIT	623,547		623,547	3,727	167.31	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	510,131		510,131	5,802	87.92	34.00
41.00	SUBPROVIDER - IRF	452,267	0	452,267	11,220	40.31	41.00
43.00	NURSERY	544,246		544,246	1,406	387.09	43.00
200.00	Total (lines 30 through 199)	6,804,499		6,804,499	92,783		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	23,720	1,569,790				30.00
31.00	INTENSIVE CARE UNIT	1,562	261,338				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,755	154,300				34.00
41.00	SUBPROVIDER - IRF	7,815	315,023				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	34,852	2,300,451				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,015,330	191,152,700	0.026237	28,108,798	737,491	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,673	9,555,059	0.021420	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,197,466	94,878,162	0.044241	8,521,674	377,007	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	169,534	161,809	1.047741	0	0	55.00
56.00	05600	RADIOISOTOPE	1,794,356	43,515,411	0.041235	8,457,612	348,750	56.00
57.00	05700	CT SCAN	1,008,921	125,595,026	0.008033	21,630,986	173,762	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	201,309	37,895,931	0.005312	5,764,417	30,621	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,141,812	113,491,817	0.010061	17,521,213	176,281	59.00
60.00	06000	LABORATORY	1,191,125	237,522,353	0.005015	48,053,069	240,986	60.00
64.00	06400	INTRAVENOUS THERAPY	25,572	8,070,502	0.003169	28,218	89	64.00
65.00	06500	RESPIRATORY THERAPY	428,481	39,872,350	0.010746	11,994,608	128,894	65.00
66.00	06600	PHYSICAL THERAPY	501,466	97,540,844	0.005141	7,578,877	38,963	66.00
69.00	06900	ELECTROCARDIOLOGY	751,061	48,190,234	0.015585	10,776,379	167,950	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,618	4,992,439	0.004931	417,714	2,060	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,781	134,843,228	0.001274	26,258,471	33,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,844	114,330,713	0.001687	26,640,165	44,942	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,977	120,402,539	0.002649	25,230,211	66,835	73.00
74.00	07400	RENAL DIALYSIS	287,656	8,030,785	0.035819	3,249,141	116,381	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	1,271	1,408,188	0.000903	175,553	159	76.10
76.97	07697	CARDIAC REHABILITATION	67,040	2,385,416	0.028104	4,945	139	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	935,633	185,590,392	0.005041	27,276,702	137,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	712,310	68,111,536	0.010458	3,945,433	41,261	92.00
200.00		Total (lines 50 through 199)	19,343,236	1,687,537,434		281,634,186	2,863,526	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0007		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 9:54 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	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
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	70,628	0.00	23,720		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	3,727	0.00	1,562		31.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	5,802	0.00	1,755		34.00		
41.00	04100	SUBPROVIDER - IRF	0	0	11,220	0.00	7,815		41.00		
43.00	04300	NURSERY		0	1,406	0.00	0		43.00		
200.00		Total (lines 30 through 199)		0	92,783		34,852		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0								34.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	405,168	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	405,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:54 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	191,152,700	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,555,059	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	94,878,162	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	161,809	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	43,515,411	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	125,595,026	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	37,895,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	113,491,817	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	237,522,353	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	8,070,502	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	39,872,350	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	97,540,844	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	48,190,234	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,992,439	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	134,843,228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	114,330,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	405,168	405,168	120,402,539	0.003365	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,030,785	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	1,408,188	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,385,416	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	185,590,392	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	68,111,536	0.000000	92.00
200.00		Total (lines 50 through 199)	0	405,168	405,168	1,687,537,434		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:54 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	28,108,798	0	24,052,368	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	8,521,674	0	10,508,097	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	14,249	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	8,457,612	0	6,346,587	0	56.00
57.00	05700	CT SCAN	0.000000	21,630,986	0	15,479,480	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,764,417	0	5,866,966	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	17,521,213	0	30,249,573	0	59.00
60.00	06000	LABORATORY	0.000000	48,053,069	0	15,026,460	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	28,218	0	3,071,831	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	11,994,608	0	1,126,636	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,578,877	0	4,639,293	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	10,776,379	0	4,823,933	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	417,714	0	842,930	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	26,258,471	0	18,521,479	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	26,640,165	0	14,915,789	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003365	25,230,211	84,900	13,812,874	46,480	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,249,141	0	115,273	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.000000	175,553	0	6,392	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	4,945	0	1,093,483	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	27,276,702	0	16,749,738	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,945,433	0	10,684,377	0	92.00
200.00		Total (lines 50 through 199)		281,634,186	84,900	197,947,808	46,480	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0007		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 9:54 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	0.211870	24,052,368	5	0	5,095,975	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296285	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140286	10,508,097	0	0	1,474,139	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	7.295892	14,249	0	0	103,959	55.00
56.00	05600	RADIOISOTOPE	0.186127	6,346,587	0	0	1,181,271	56.00
57.00	05700	CT SCAN	0.026571	15,479,480	0	0	411,305	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041883	5,866,966	0	0	245,726	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.120550	30,249,573	0	0	3,646,586	59.00
60.00	06000	LABORATORY	0.093924	15,026,460	22,387	0	1,411,345	60.00
64.00	06400	INTRAVENOUS THERAPY	0.165380	3,071,831	1	0	508,019	64.00
65.00	06500	RESPIRATORY THERAPY	0.141795	1,126,636	0	0	159,751	65.00
66.00	06600	PHYSICAL THERAPY	0.163770	4,639,293	0	0	759,777	66.00
69.00	06900	ELECTROCARDIOLOGY	0.073471	4,823,933	0	0	354,419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.088126	842,930	0	0	74,284	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147299	18,521,479	0	0	2,728,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.197031	14,915,789	0	0	2,938,873	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262166	13,812,874	0	29,591	3,621,266	73.00
74.00	07400	RENAL DIALYSIS	0.303236	115,273	0	0	34,955	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.091834	6,392	0	20	587	76.10
76.97	07697	CARDIAC REHABILITATION	0.236568	1,093,483	0	0	258,683	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.101595	16,749,738	4	47	1,701,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.206008	10,684,377	0	6	2,201,067	92.00
200.00		Subtotal (see instructions)		197,947,808	22,397	29,664	28,911,872	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	0	201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		197,947,808	22,397	29,664	28,911,872	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 9:54 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	1	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	2,103	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,758		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	2		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	5		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1		92.00
200.00		Subtotal (see instructions)	2,104	7,766		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,104	7,766		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 9:54 am		
				Component CCN: 14-T007				
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,015,330	191,152,700	0.026237	69,353	1,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	204,673	9,555,059	0.021420	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,197,466	94,878,162	0.044241	349,890	15,479	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	169,534	161,809	1.047741	0	0	55.00
56.00	05600	RADIOISOTOPE	1,794,356	43,515,411	0.041235	167,349	6,901	56.00
57.00	05700	CT SCAN	1,008,921	125,595,026	0.008033	668,197	5,368	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	201,309	37,895,931	0.005312	245,626	1,305	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,141,812	113,491,817	0.010061	284,793	2,865	59.00
60.00	06000	LABORATORY	1,191,125	237,522,353	0.005015	4,027,626	20,199	60.00
64.00	06400	INTRAVENOUS THERAPY	25,572	8,070,502	0.003169	594	2	64.00
65.00	06500	RESPIRATORY THERAPY	428,481	39,872,350	0.010746	575,636	6,186	65.00
66.00	06600	PHYSICAL THERAPY	501,466	97,540,844	0.005141	16,113,515	82,840	66.00
69.00	06900	ELECTROCARDIOLOGY	751,061	48,190,234	0.015585	154,604	2,410	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,618	4,992,439	0.004931	21,214	105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,781	134,843,228	0.001274	663,867	846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,844	114,330,713	0.001687	49,809	84	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,977	120,402,539	0.002649	2,016,264	5,341	73.00
74.00	07400	RENAL DIALYSIS	287,656	8,030,785	0.035819	511,851	18,334	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	1,271	1,408,188	0.000903	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	67,040	2,385,416	0.028104	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	935,633	185,590,392	0.005041	37,713	190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	68,111,536	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	18,630,926	1,687,537,434		25,957,901	170,275	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 9:54 am	
			Title XVIII		Subprovider - IRF		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	405,168	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	405,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 9:54 am	
			Title XVIII		Subprovider - IRF		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	191,152,700	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,555,059	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	94,878,162	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	161,809	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	43,515,411	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	125,595,026	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	37,895,931	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	113,491,817	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	237,522,353	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	8,070,502	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	39,872,350	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	97,540,844	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	48,190,234	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,992,439	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	134,843,228	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	114,330,713	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	405,168	405,168	120,402,539	0.003365	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,030,785	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	1,408,188	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,385,416	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	185,590,392	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	68,111,536	0.000000	92.00
200.00		Total (lines 50 through 199)	0	405,168	405,168	1,687,537,434		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 9:54 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	69,353	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	349,890	0	1,493	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	167,349	0	25	0	56.00
57.00	05700	CT SCAN		0.000000	668,197	0	8,744	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	245,626	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	284,793	0	2,934	0	59.00
60.00	06000	LABORATORY		0.000000	4,027,626	0	97	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	594	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	575,636	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	16,113,515	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	154,604	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	21,214	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	663,867	0	830	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	49,809	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.003365	2,016,264	6,785	1,368	5	73.00
74.00	07400	RENAL DIALYSIS		0.000000	511,851	0	0	0	74.00
76.00	03950	OTHER ANCILLARY		0.000000	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH		0.000000	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0.000000	37,713	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			25,957,901	6,785	15,491	5	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:

Worksheet D

Component CCN: 14-T007

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/29/2021 9:54 am

Title XVIII

Subprovider -
IRF

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	0.211870	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296285	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140286	1,493	0	209	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	7.295892	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.186127	25	0	5	56.00
57.00	05700	CT SCAN	0.026571	8,744	0	232	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041883	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.120550	2,934	0	354	59.00
60.00	06000	LABORATORY	0.093924	97	0	9	60.00
64.00	06400	INTRAVENOUS THERAPY	0.165380	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141795	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.163770	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.073471	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.088126	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147299	830	0	122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.197031	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262166	1,368	0	359	73.00
74.00	07400	RENAL DIALYSIS	0.303236	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.091834	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.236568	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.101595	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.206008	0	0	0	92.00
200.00		Subtotal (see instructions)		15,491	0	4,147	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		15,491	0	4,147	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:

Worksheet D

Component CCN: 14-T007

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/29/2021 9:54 am

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Costs		
			Cost	Cost	
			Reimbursed	Reimbursed	
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,087	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
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	1,087	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,087	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:54 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)		70,628	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,628	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)		59,865	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)		23,720	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)		92,076,568	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)		92,076,568	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)		92,076,568	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)		1,303.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		30,923,290	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		30,923,290	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 9:54 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	11,542,761	3,727	3,097.06	1,562	4,837,608
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT	12,924,235	5,802	2,227.55	1,755	3,909,350
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)					40,260,989
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					79,931,237
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,985,428
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,948,426
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,933,854
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					74,997,383
	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)					10,763
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,303.68
89.00	Observation bed cost (line 87 x line 88) (see instructions)					14,031,508

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 9:54 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	4,674,308	92,076,568	0.050765	14,031,508	712,310	90.00
91.00 Nursing School cost	0	92,076,568	0.000000	14,031,508	0	91.00
92.00 Allied health cost	0	92,076,568	0.000000	14,031,508	0	92.00
93.00 All other Medical Education	0	92,076,568	0.000000	14,031,508	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:54 am
		Title XVIII	Subprovider - IRF	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)		11,220	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,220	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)		11,220	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)		7,815	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)		11,742,135	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)		11,742,135	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)		11,742,135	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)		1,046.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,178,710	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)		8,178,710	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:54 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,065,581	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,244,291	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)					315,023	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					177,060	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					492,083	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,752,208	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:54 am	
		Title XVIII		Subprovider - IRF	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	452,267	11,742,135	0.038517	0	0	90.00
91.00 Nursing School cost	0	11,742,135	0.000000	0	0	91.00
92.00 Allied health cost	0	11,742,135	0.000000	0	0	92.00
93.00 All other Medical Education	0	11,742,135	0.000000	0	0	93.00

Health Financial Systems		PRESENCE ST. JOSEPH MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 9:54 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		83,811,134	30.00
31.00	03100	INTENSIVE CARE UNIT		10,533,475	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		17,623,777	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.211870	28,108,798	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.296285	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140286	8,521,674	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	7.295892	0	55.00
56.00	05600	RADIOISOTOPE	0.186127	8,457,612	56.00
57.00	05700	CT SCAN	0.026571	21,630,986	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.041883	5,764,417	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.120550	17,521,213	59.00
60.00	06000	LABORATORY	0.093924	48,053,069	60.00
64.00	06400	INTRAVENOUS THERAPY	0.165380	28,218	64.00
65.00	06500	RESPIRATORY THERAPY	0.141795	11,994,608	65.00
66.00	06600	PHYSICAL THERAPY	0.163825	7,578,877	66.00
69.00	06900	ELECTROCARDIOLOGY	0.073471	10,776,379	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.088126	417,714	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147299	26,258,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.197031	26,640,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262166	25,230,211	73.00
74.00	07400	RENAL DIALYSIS	0.303236	3,249,141	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.091834	175,553	76.10
76.97	07697	CARDIAC REHABILITATION	0.236568	4,945	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.101624	27,276,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.206008	3,945,433	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		281,634,186	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)		281,634,186	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 9:54 am	
		Title XVIII	Subprovider - IRF	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				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
41.00	04100 SUBPROVIDER - IRF		24,051,703		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.211870	69,353	14,694	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.296285	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140286	349,890	49,085	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	7.295892	0	0	55.00
56.00	05600 RADIOISOTOPE	0.186127	167,349	31,148	56.00
57.00	05700 CT SCAN	0.026571	668,197	17,755	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.041883	245,626	10,288	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.120550	284,793	34,332	59.00
60.00	06000 LABORATORY	0.093924	4,027,626	378,291	60.00
64.00	06400 INTRAVENOUS THERAPY	0.165380	594	98	64.00
65.00	06500 RESPIRATORY THERAPY	0.141795	575,636	81,622	65.00
66.00	06600 PHYSICAL THERAPY	0.163825	16,113,515	2,639,797	66.00
69.00	06900 ELECTROCARDIOLOGY	0.073471	154,604	11,359	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.088126	21,214	1,870	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.147299	663,867	97,787	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.197031	49,809	9,814	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262166	2,016,264	528,596	73.00
74.00	07400 RENAL DIALYSIS	0.303236	511,851	155,212	74.00
76.00	03950 OTHER ANCILLARY	0.000000	0	0	76.00
76.10	03550 OUTPATIENT PSYCH	0.091834	0	0	76.10
76.97	07697 CARDIAC REHABILITATION	0.236568	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.101624	37,713	3,833	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.206008	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		25,957,901	4,065,581	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)		25,957,901		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 9:54 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)			11,500,934	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			42,015,645	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)			177,293	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			1,405,232	2.04
3.00	Managed Care Simulated Payments			22,962,003	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			402.45	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)			9.00	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)			5.85	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)			5.85	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)			9.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			3.25	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.98	11.00
12.00	Current year allowable FTE (see instructions)			4.23	12.00
13.00	Total allowable FTE count for the prior year.			4.92	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.			5.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			4.72	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			4.72	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.011728	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.012260	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.011728	21.00
22.00	IME payment adjustment (see instructions)			341,971	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			146,727	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			-5.75	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)			341,971	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			146,727	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			3.61	30.00
31.00	Percentage of Medicaid patient days (see instructions)			20.34	31.00
32.00	Sum of lines 30 and 31			23.95	32.00
33.00	Allowable disproportionate share percentage (see instructions)			8.97	33.00
34.00	Disproportionate share adjustment (see instructions)			1,200,110	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 9:54 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,164,501	3,268,873		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,046,814	2,444,937		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,491,751			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
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	60,132,936			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)		60,279,663		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,453,830		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).		205,578		52.00
53.00	Nursing and Allied Health Managed Care payment		43,545		53.00
54.00	Special add-on payments for new technologies		487,693		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 intructions)		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)		84,900		58.00
59.00	Total (sum of amounts on lines 49 through 58)		65,555,209		59.00
60.00	Primary payer payments		18,930		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		65,536,279		61.00
62.00	Deductibles billed to program beneficiaries		4,858,416		62.00
63.00	Coinsurance billed to program beneficiaries		220,685		63.00
64.00	Allowable bad debts (see instructions)		1,431,234		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		930,302		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		583,553		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		61,387,480		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-73,800		70.93
70.94	HRR adjustment amount (see instructions)		-588,697		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 9:54 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)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		60,724,983	71.00
71.01	Sequestration adjustment (see instructions)		0	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		59,215,449	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)		1,509,534	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		985,809	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 9:54 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	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,500,934	0	11,500,934		11,500,934	1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	42,015,645	0		42,015,645	42,015,645	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00						2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01	
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	177,293	0	177,293		177,293	2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,405,232	0		1,405,232	1,405,232	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	22,962,003	0	4,230,831	18,731,172	22,962,003	4.00	
Indirect Medical Education Adjustment									
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.011728	0.011728	0.011728	0.011728		5.00	
6.00	IME payment adjustment (see instructions)	22.00	341,971	0	73,491	268,480	341,971	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	146,727	0	27,035	119,692	146,727	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA									
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	341,971	0	73,491	268,480	341,971	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	146,727	0	27,035	119,692	146,727	9.01	
Disproportionate Share Adjustment									
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0897	0.0897	0.0897	0.0897		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	1,200,110	0	257,909	942,201	1,200,110	11.00	
11.01	Uncompensated care payments	36.00	3,491,751	0	1,112,875	3,117,687	4,230,562	11.01	
Additional payment for high percentage of ESRD beneficiary discharges									
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	60,132,936	0	13,122,502	47,010,434	60,132,936	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	60,279,663	0	13,149,537	47,130,126	60,279,663	15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	4,453,830	0	967,116	3,486,714	4,453,830	16.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 9:54 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	487,693	0	0	487,693	487,693	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	14,116,653	51,104,533	65,221,186	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	4,113,500	0	906,290	3,207,210	4,113,500	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	107,094	0	9,439	97,655	107,094	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	0.0070	0.0070	0.0070	0.0070		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	28,795	0	6,344	22,451	28,795	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0497	0.0497	0.0497	0.0497		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	204,441	0	45,043	159,398	204,441	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,453,830	0	967,116	3,486,714	4,453,830	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 9:54 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	11,500,934	11,500,934		11,500,934	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	42,015,645		42,015,645	42,015,645	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	177,293	177,293		177,293	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,405,232		1,405,232	1,405,232	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	22,962,003	4,230,831	18,731,172	22,962,003	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.011728	0.011728	0.011728		5.00
6.00	IME payment adjustment (see instructions)	22.00	341,971	73,491	268,480	341,971	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	146,727	27,035	119,692	146,727	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	341,971	73,491	268,480	341,971	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	146,727	27,035	119,692	146,727	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0897	0.0897	0.0897		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,200,110	257,909	942,201	1,200,110	11.00
11.01	Uncompensated care payments	36.00	3,491,751	1,046,814	2,444,937	3,491,751	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	60,132,936	13,056,441	47,076,495	60,132,936	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	60,279,663	13,083,476	47,196,187	60,279,663	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	4,453,830	967,116	3,486,714	4,453,830	16.00
17.00	Special add-on payments for new technologies	54.00	487,693	0	487,693	487,693	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			14,050,592	51,170,594	65,221,186	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 9:54 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	4,113,500	906,290	3,207,210	4,113,500	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	107,094	9,439	97,655	107,094	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	0.0070	0.0070	0.0070		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	28,795	6,344	22,451	28,795	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0497	0.0497	0.0497		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	204,441	45,043	159,398	204,441	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,453,830	967,116	3,486,714	4,453,830	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	-73,800	12,776	-86,576	-73,800	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	-588,697	-167,914	-420,783	-588,697	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 9:54 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,870	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		28,865,392	2.00
3.00	OPPS payments		22,675,779	3.00
4.00	Outlier payment (see instructions)		361,905	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		46,480	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9,870	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		52,061	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)		52,061	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)		52,061	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		42,191	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)		9,870	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)		23,084,164	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		35	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,819,089	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)		19,274,910	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		64,522	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)		19,339,432	30.00
31.00	Primary payer payments		200	31.00
32.00	Subtotal (line 30 minus line 31)		19,339,232	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)		647,842	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		421,097	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		229,134	36.00
37.00	Subtotal (see instructions)		19,760,329	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		19,760,329	40.00
40.01	Sequestration adjustment (see instructions)		0	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		19,726,980	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)		33,349	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 9:54 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,087	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,285	2.00
3.00	OPPS payments		1,293	3.00
4.00	Outlier payment (see instructions)		0	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		5	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,087	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,147	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)		4,147	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		4,147	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,060	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)		1,087	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)		1,298	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)		111	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)		2,274	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)		2,274	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,274	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,274	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)		2,274	40.00
40.01	Sequestration adjustment (see instructions)		0	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		2,184	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)		90	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: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 9:54 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		58,336,946		19,222,740	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		897,454		514,026	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	03/03/2021	18,951	03/03/2021	9,786	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)		-18,951		-9,786	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)		59,215,449		19,726,980	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		1,509,534		33,349	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		60,724,983		19,760,329	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0007
 Component CCN: 14-T007

 Period:
 From 07/01/2020
 To 06/30/2021

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/29/2021 9:54 am

		Title XVIII		Subprovider - IRF		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		13,752,460		2,184	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	03/03/2021	16,577		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)		-16,577		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)		13,735,883		2,184	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		107,103		90	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		13,842,986		2,274	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/29/2021 9:54 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/29/2021 9:54 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			13,437,594 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0186 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			378,940 3.00
4.00	Outlier Payments			91,988 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			30.739726 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			13,908,522 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			13,908,522 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			13,908,522 19.00
20.00	Deductibles			71,044 20.00
21.00	Subtotal (line 19 minus line 20)			13,837,478 21.00
22.00	Coinsurance			21,919 22.00
23.00	Subtotal (line 21 minus line 22)			13,815,559 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			31,757 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			20,642 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,964 26.00
27.00	Subtotal (sum of lines 23 and 25)			13,836,201 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			6,785 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			13,842,986 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			13,735,883 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			107,103 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			91,988 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0007		Period: From 07/01/2020 To 06/30/2021		Worksheet E-4 Date/Time Prepared: 11/29/2021 9:54 am	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					9.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					5.85	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					5.85	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					9.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					3.25	6.00
7.00	Enter the lesser of line 5 or line 6					3.25	7.00
		Primary Care		Other		Total	
		1.00		2.00		3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00		2.29		2.29 8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00		2.29		2.29 9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year			0.98		10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			0.00		10.01	
11.00	Total weighted FTE count	0.00		3.27		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00		3.00		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00		4.29		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00		3.52		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00		0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00		0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00		0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00		0.00		16.01	
17.00	Adjusted rolling average FTE count	0.00		3.52		17.00	
18.00	Per resident amount	129,122.32		129,122.32		18.00	
19.00	Approved amount for resident costs	0		454,511		19.00	
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00 20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00 21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00 22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00 23.00	
24.00	Multiply line 22 time line 23					0 24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)					454,511 25.00	
		Inpatient Part A		Managed Care Prior to 1/1		Managed Care On or after 1/1	
		1.00		2.00		2.01	
						3.00	
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	34,852		5,952		7,796 26.00	
27.00	Total Inpatient Days (see instructions)	80,840		80,840		80,840 27.00	
28.00	Ratio of inpatient days to total inpatient days	0.431123		0.073627		0.096437 28.00	
29.00	Program direct GME amount	195,950		33,464		43,832 29.00	
29.01	Percent reduction for MA DGME			4.07		4.07 29.01	
30.00	Reduction for direct GME payments for Medicare Advantage			1,362		1,784 30.00	
31.00	Net Program direct GME amount					270,100 31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 9:54 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			8,030,785	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			92,175,528	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			18,930	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			92,156,598	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			28,924,119	42.00
43.00	Primary payer payments (see instructions)			200	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			28,923,919	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			121,080,517	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.761118	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.238882	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			270,100	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			205,578	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			64,522	50.00

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

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:

11/29/2021 9:54 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	335,769	0	0	0	1.00
2.00 Temporary investments	1,461,554	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	206,379,095	0	0	0	4.00
5.00 Other receivable	169,207	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-153,695,309	0	0	0	6.00
7.00 Inventory	8,593,800	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	12,662,236	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)	75,906,352	0	0	0	11.00
FIXED ASSETS					
12.00 Land	7,950,000	0	0	0	12.00
13.00 Land improvements	1,188,596	0	0	0	13.00
14.00 Accumulated depreciation	-914,993	0	0	0	14.00
15.00 Buildings	113,633,213	0	0	0	15.00
16.00 Accumulated depreciation	-13,370,054	0	0	0	16.00
17.00 Leasehold improvements	3,063,777	0	0	0	17.00
18.00 Accumulated depreciation	-564,652	0	0	0	18.00
19.00 Fixed equipment	3,401,383	0	0	0	19.00
20.00 Accumulated depreciation	-826,369	0	0	0	20.00
21.00 Automobiles and trucks	21,638	0	0	0	21.00
22.00 Accumulated depreciation	-16,028	0	0	0	22.00
23.00 Major movable equipment	28,100,244	0	0	0	23.00
24.00 Accumulated depreciation	-17,217,967	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	124,448,788	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	23,139,481	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	23,139,481	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	223,494,621	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	15,249,236	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,032,557	0	0	0	38.00
39.00 Payroll taxes payable	717,238	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	126,752,730	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	145,751,761	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	25,091,486	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	25,091,486	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	170,843,247	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	52,651,374				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)	52,651,374	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	223,494,621	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/29/2021 9:54 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		49,745,533		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,382,731				2.00
3.00	Total (sum of line 1 and line 2)		52,128,264		0		3.00
4.00	NET ASSET TRANSFER	523,110		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		523,110		0		10.00
11.00	Subtotal (line 3 plus line 10)		52,651,374		0		11.00
12.00	NET ASSET TRANSFER	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)		52,651,374		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	NET ASSET TRANSFER		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	NET ASSET TRANSFER		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 9:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	215,308,542		215,308,542	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	34,221,724		34,221,724	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)	249,530,266		249,530,266	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	34,918,222		34,918,222	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	49,873,548		49,873,548	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	84,791,770		84,791,770	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	334,322,036		334,322,036	17.00
18.00	Ancillary services	671,961,503	761,874,004	1,433,835,507	18.00
19.00	Outpatient services	74,328,526	179,373,402	253,701,928	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	NON-REIMBURSABLE	309,591	2,244,750	2,554,341	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,080,921,656	943,492,156	2,024,413,812	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		367,174,538		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)		367,174,538		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0007

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/29/2021 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,024,413,812	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,686,225,892	2.00
3.00	Net patient revenues (line 1 minus line 2)	338,187,920	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	367,174,538	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-28,986,618	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	805,585	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,154,373	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	748,210	24.00
24.01	OTHER (SPECIFY)	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.50	COVID-19 PHE Funding	28,661,181	24.50
25.00	Total other income (sum of lines 6-24)	31,369,349	25.00
26.00	Total (line 5 plus line 25)	2,382,731	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,382,731	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0007	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/29/2021 9:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,113,500	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		107,094	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		190.74	3.00
4.00	Number of interns & residents (see instructions)		4.72	4.00
5.00	Indirect medical education percentage (see instructions)		0.70	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)		28,795	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.61	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		20.34	8.00
9.00	Sum of lines 7 and 8		23.95	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.97	10.00
11.00	Disproportionate share adjustment (see instructions)		204,441	11.00
12.00	Total prospective capital payments (see instructions)		4,453,830	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