

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: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet S Parts I-III Date/Time Prepared: 8/23/2021 1:55 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/23/2021	Time: 1:55 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL (14-0011) for the cost reporting period beginning 04/01/2020 and ending 03/31/2021 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-7,503,957	-73,931	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	65,037	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-7,438,920	-73,931	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: 14-0011		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 1:52 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 201 S. 14TH STREET			PO Box:				1.00	
2.00	City: HERRIN			State: IL		Zip Code: 62948		County:	
		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			HERRIN HOSPITAL	140011	16060	1	07/01/1966	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF			HERRIN HOSPITAL ACUTE REHAB	14T011	16060	5	04/01/1998	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)						04/01/2020	03/31/2021	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			404	32	0	0	3,166	244

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	203	0	0	0	905		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					04/01/2020	03/31/2021	38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
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To 03/31/2021Worksheet S-2
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/23/2021 1:52 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,711,029	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	140.00

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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: SOUTHERN ILLINOIS HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 06101				141.00
142.00	Street: 1239 E MAIN STREET		PO Box: 3988						142.00
143.00	City: CARBONDALE		State: IL		Zip Code: 62902-3988				143.00
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									1.00
									2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
									1.00
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
									1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/23/2021 1:52 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		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.		Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/13/2021	Y 07/13/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		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		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		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.		Y		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.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR		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

Health Financial Systems		HERRIN HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part IX Date/Time Prepared: 8/23/2021 1:52 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State		
			1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0011

Period:
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To 03/31/2021Worksheet S-3
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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	77	28,105	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)		77	28,105	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		85	31,025	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	29	10,585		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)		114			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

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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)	12,198	369	21,600			1.00
2.00	HMO and other (see instructions)	2,418	3,410				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	643	905				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)	12,198	369	21,600			7.00
8.00	INTENSIVE CARE UNIT	1,338	67	2,218			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)	13,536	436	23,818	0.00	688.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	4,906	203	7,820	0.00	55.89	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	743.92	27.00
28.00	Observation Bed Days		28	1,619			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	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,928	91	5,604	1.00
2.00 HMO and other (see instructions)			501	919		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				60		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,928	91	5,604	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	287	10	461	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part II
Date/Time Prepared:
8/23/2021 1:52 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	51,309,663	0	51,309,663	1,547,352.59	33.16
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		301,778	0	301,778	5,781.32	52.20
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,963,149	-153,217	3,809,932	117,331.45	32.47
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		395,826	0	395,826	6,316.25	62.67
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		49,662	0	49,662	249.75	198.85
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		9,620,391	0	9,620,391	227,155.82	42.35
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,079,228	0	8,079,228		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		652,175	0	652,175		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		51,658	0	51,658		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,192,467	0	3,192,467		
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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part II
Date/Time Prepared:
8/23/2021 1:52 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	144,000	0	144,000	3,802.45	37.87	26.00
27.00	Administrative & General	5.00	4,873,282	0	4,873,282	121,903.48	39.98	27.00
28.00	Administrative & General under contract (see inst.)		283,429	0	283,429	672.63	421.37	28.00
29.00	Maintenance & Repairs	6.00	608,764	0	608,764	22,946.95	26.53	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	50,961	0	50,961	3,043.52	16.74	31.00
32.00	Housekeeping	9.00	1,273,248	0	1,273,248	78,565.36	16.21	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,165,537	-733,518	432,019	23,539.12	18.35	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	733,518	733,518	39,959.99	18.36	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	947,965	0	947,965	22,896.15	41.40	38.00
39.00	Central Services and Supply	14.00	206,876	0	206,876	11,573.16	17.88	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	369,635	0	369,635	15,613.96	23.67	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part III
Date/Time Prepared:
8/23/2021 1:52 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	51,291,314	0	51,291,314	1,542,243.90	33.26	1.00
2.00	Excluded area salaries (see instructions)	3,963,149	-153,217	3,809,932	117,331.45	32.47	2.00
3.00	Subtotal salaries (line 1 minus line 2)	47,328,165	153,217	47,481,382	1,424,912.45	33.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,065,879	0	10,065,879	233,721.82	43.07	4.00
5.00	Subtotal wage-related costs (see inst.)	11,271,695	0	11,271,695	0.00	23.74	5.00
6.00	Total (sum of lines 3 thru 5)	68,665,739	153,217	68,818,956	1,658,634.27	41.49	6.00
7.00	Total overhead cost (see instructions)	9,923,697	0	9,923,697	344,516.77	28.80	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
8/23/2021 1:52 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	839,632	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)	2,741,988	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	24,847	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,000	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)	131,349	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	486,130	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	573,498	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,745,852	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	75,207	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))	53,639	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	73,919	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,783,061	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part V
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	395,826	8,783,061	1.00
2.00	Hospital	395,826	8,783,061	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet S-10

Date/Time Prepared:
8/23/2021 1:52 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.203027	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		14,767,412	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,156,883	5.00
6.00	Medicaid charges		139,871,636	6.00
7.00	Medicaid cost (line 1 times line 6)		28,397,719	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		11,473,424	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		1,332	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		11,473,424	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)	4,530,215	1,504,970	6,035,185
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	919,756	1,504,970	2,424,726
22.00	Payments received from patients for amounts previously written off as charity care	0	90	90
23.00	Cost of charity care (line 21 minus line 22)	919,756	1,504,880	2,424,636
		1.00	2.00	3.00
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)		8,988,987	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,220,392	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,877,526	27.01
28.00	Non-Medicare bad debt expense (see instructions)		7,111,461	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,100,953	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,525,589	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		15,999,013	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,770,096	4,770,096	948,545	5,718,641	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,333,334	3,333,334	312,147	3,645,481	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144,000	13,356,875	13,500,875	0	13,500,875	4.00
5.01	00550	DATA PROCESSING	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	213,509	25,883	239,392	0	239,392	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	970,366	30,771	1,001,137	0	1,001,137	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,689,407	8,699,189	12,388,596	0	12,388,596	5.04
6.00	00600	MAINTENANCE & REPAIRS	608,764	1,194,713	1,803,477	0	1,803,477	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,961	708,469	759,430	0	759,430	8.00
9.00	00900	HOUSEKEEPING	1,273,248	371,402	1,644,650	0	1,644,650	9.00
10.00	01000	DIETARY	1,165,537	861,132	2,026,669	-1,275,463	751,206	10.00
11.00	01100	CAFETERIA	0	0	0	1,275,463	1,275,463	11.00
13.00	01300	NURSING ADMINISTRATION	947,965	84,131	1,032,096	0	1,032,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	206,876	48,121	254,997	-4,094	250,903	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,635	7,630	377,265	0	377,265	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	4,329,105	4,329,105	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,194,345	8,181,974	18,376,319	-41,449	18,334,870	30.00
31.00	03100	INTENSIVE CARE UNIT	2,035,840	544,598	2,580,438	-31,291	2,549,147	31.00
41.00	04100	SUBPROVIDER - IRF	3,783,454	1,655,604	5,439,058	-7,073	5,431,985	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,253,798	7,060,790	11,314,588	-2,905,082	8,409,506	50.00
51.00	05100	RECOVERY ROOM	775,457	6,889	782,346	0	782,346	51.00
53.00	05300	ANESTHESIOLOGY	690,333	4,587,063	5,277,396	-4,373,941	903,455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,960,457	498,844	2,459,301	-27,476	2,431,825	54.00
56.00	05600	RADIOISOTOPE	206,953	691,043	897,996	-2,423	895,573	56.00
57.00	05700	CT SCAN	522,913	761,122	1,284,035	-55,247	1,228,788	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	292,663	549,309	841,972	-58,406	783,566	58.00
60.00	06000	LABORATORY	1,861,432	5,482,376	7,343,808	182,859	7,526,667	60.00
65.00	06500	RESPIRATORY THERAPY	1,205,683	296,322	1,502,005	-92,913	1,409,092	65.00
66.00	06600	PHYSICAL THERAPY	6,288,427	1,583,587	7,872,014	-249	7,871,765	66.00
69.00	06900	ELECTROCARDIOLOGY	1,303,592	744,789	2,048,381	-294,400	1,753,981	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,357,016	3,357,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,051,060	6,051,060	0	6,051,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,224,706	6,163,297	8,388,003	419,840	8,807,843	73.00
76.97	07697	CARDIAC REHABILITATION	329,414	8,072	337,486	-100	337,386	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	264,196	79,820	344,016	-276	343,740	90.00
91.00	09100	EMERGENCY	3,296,037	5,391,709	8,687,746	-25,349	8,662,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,810,526	1,810,526	-1,260,692	549,834	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,129,968	85,640,540	136,770,508	369,051	137,139,559	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	378,357	378,357	0	378,357	192.00
192.01	19201	OUTREACH LAB	153,217	215,837	369,054	0	369,054	192.01
192.02	19202	THERAPY CASH BASED SERVICES	26,478	186	26,664	-369,051	-342,387	192.02
192.03	19203	VACANT SPACE	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	51,309,663	86,234,920	137,544,583	0	137,544,583	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-188,241	5,530,400	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,495,500	6,140,981	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-136,610	13,364,265	4.00
5.01	00550	DATA PROCESSING	7,655,491	7,655,491	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-6,815	232,577	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,175,184	3,176,321	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,324,923	14,713,519	5.04
6.00	00600	MAINTENANCE & REPAIRS	-36,302	1,767,175	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	759,430	8.00
9.00	00900	HOUSEKEEPING	0	1,644,650	9.00
10.00	01000	DIETARY	0	751,206	10.00
11.00	01100	CAFETERIA	-564,036	711,427	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,032,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	250,903	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-47,393	329,872	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-4,329,105	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,605,900	13,728,970	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,549,147	31.00
41.00	04100	SUBPROVIDER - IRF	-1,616,698	3,815,287	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-31,060	8,378,446	50.00
51.00	05100	RECOVERY ROOM	0	782,346	51.00
53.00	05300	ANESTHESIOLOGY	0	903,455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-37,637	2,394,188	54.00
56.00	05600	RADIOISOTOPE	0	895,573	56.00
57.00	05700	CT SCAN	0	1,228,788	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	783,566	58.00
60.00	06000	LABORATORY	-277,407	7,249,260	60.00
65.00	06500	RESPIRATORY THERAPY	-2,135	1,406,957	65.00
66.00	06600	PHYSICAL THERAPY	-85,167	7,786,598	66.00
69.00	06900	ELECTROCARDIOLOGY	-78,385	1,675,596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,357,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,051,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-300	8,807,543	73.00
76.97	07697	CARDIAC REHABILITATION	1,700	339,086	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,866	341,874	90.00
91.00	09100	EMERGENCY	-3,905,564	4,756,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-549,834	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,847,657	135,291,902	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-117,926	260,431	192.00
192.01	19201	OUTREACH LAB	0	369,054	192.01
192.02	19202	THERAPY CASH BASED SERVICES	-17,250	-359,637	192.02
192.03	19203	VACANT SPACE	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,982,833	135,561,750	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet Non-CMS W

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	OUTREACH LAB	19201		192.01
192.02	THERAPY CASH BASED SERVICES	19202		192.02
192.03	VACANT SPACE	19203		192.03
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet A-6
Date/Time Prepared:
8/23/2021 1:52 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	733,518	541,945	1.00
	TOTALS		733,518	541,945	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,357,016	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
	TOTALS		0	3,357,016	
C - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,329,105	1.00
	TOTALS		0	4,329,105	
D - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	948,545	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	312,147	2.00
	TOTALS		0	1,260,692	
E - CONTRAST DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	420,780	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
	TOTALS		0	420,780	
F - REFERENCE LAB RECLASS					
1.00	LABORATORY	60.00	153,217	215,834	1.00
	TOTALS		153,217	215,834	
500.00	Grand Total: Increases		886,735	10,125,372	500.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/23/2021 1:52 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	733,518	541,945	0		1.00
	TOTALS		733,518	541,945			
	B - MEDICAL SUPPLY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	41,449	0		1.00
2.00	SUBPROVIDER - IRF	41.00	0	7,073	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	31,291	0		3.00
4.00	OPERATING ROOM	50.00	0	2,899,307	0		4.00
5.00	RADIOISOTOPE	56.00	0	2,423	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,094	0		6.00
7.00	EMERGENCY	91.00	0	25,349	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	44,836	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,494	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	249	0		10.00
11.00	LABORATORY	60.00	0	186,192	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	92,913	0		12.00
13.00	CARDIAC REHABILITATION	76.97	0	100	0		13.00
14.00	CLINIC	90.00	0	276	0		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	940	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	30	0		16.00
	TOTALS		0	3,357,016			
	C - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	4,329,105	0		1.00
	TOTALS		0	4,329,105			
	D - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,260,692	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,260,692			
	E - CONTRAST DRUG RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	0	294,400	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,982	0		2.00
3.00	CT SCAN	57.00	0	55,247	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	58,376	0		4.00
5.00	OPERATING ROOM	50.00	0	5,775	0		5.00
	TOTALS		0	420,780			
	F - REFERENCE LAB RECLASS						
1.00	THERAPY CASH BASED SERVICES	192.02	153,217	215,834	0		1.00
	TOTALS		153,217	215,834			
500.00	Grand Total: Decreases		886,735	10,125,372			500.00

RECLASSIFICATIONS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/23/2021 1:52 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	733,518	541,945	DIETARY	10.00	733,518	541,945	1.00
	TOTALS		733,518	541,945	TOTALS		733,518	541,945	
B - MEDICAL SUPPLY RECLASS									
1.00	MEDICAL SUPPLIES	71.00	0	3,357,016	ADULTS & PEDIATRICS	30.00	0	41,449	1.00
	CHARGED TO PATIENTS								
2.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	7,073	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	31,291	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	2,899,307	4.00
5.00		0.00	0	0	RADIOISOTOPE	56.00	0	2,423	5.00
6.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	4,094	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	25,349	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	44,836	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	20,494	9.00
10.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	249	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	186,192	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	92,913	12.00
13.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	100	13.00
14.00		0.00	0	0	CLINIC	90.00	0	276	14.00
15.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	940	15.00
16.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	30	16.00
	TOTALS		0	3,357,016	TOTALS		0	3,357,016	
C - CRNA RECLASS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,329,105	ANESTHESIOLOGY	53.00	0	4,329,105	1.00
	TOTALS		0	4,329,105	TOTALS		0	4,329,105	
D - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	948,545	INTEREST EXPENSE	113.00	0	1,260,692	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	312,147		0.00	0	0	2.00
	TOTALS		0	1,260,692	TOTALS		0	1,260,692	
E - CONTRAST DRUG RECLASS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	420,780	ELECTROCARDIOLOGY	69.00	0	294,400	1.00
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	6,982	2.00
3.00		0.00	0	0	CT SCAN	57.00	0	55,247	3.00
4.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	58,376	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	5,775	5.00
	TOTALS		0	420,780	TOTALS		0	420,780	
F - REFERENCE LAB RECLASS									
1.00	LABORATORY	60.00	153,217	215,834	THERAPY CASH BASED SERVICES	192.02	153,217	215,834	1.00
	TOTALS		153,217	215,834	TOTALS		153,217	215,834	
500.00	Grand Total: Increases		886,735	10,125,372	Grand Total: Decreases		886,735	10,125,372	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,070,283	177,385	0	177,385	0	1.00	
2.00	Land Improvements	5,896,810	29,861	0	29,861	0	2.00	
3.00	Buildings and Fixtures	96,699,633	3,606,521	0	3,606,521	807,409	3.00	
4.00	Building Improvements	35,549	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	36,742,181	5,903,280	0	5,903,280	2,432,610	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	144,444,456	9,717,047	0	9,717,047	3,240,019	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	144,444,456	9,717,047	0	9,717,047	3,240,019	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,247,668	0				1.00	
2.00	Land Improvements	5,926,671	0				2.00	
3.00	Buildings and Fixtures	99,498,745	0				3.00	
4.00	Building Improvements	35,549	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	40,212,851	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	150,921,484	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	150,921,484	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part II
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,770,096	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,333,334	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,103,430	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	4,770,096				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,333,334				2.00
3.00	Total (sum of lines 1-2)	0	8,103,430				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part III
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	110,708,633	0	110,708,633	0.733551	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,212,851	0	40,212,851	0.266449	0	2.00
3.00	Total (sum of lines 1-2)	150,921,484	0	150,921,484	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,530,400	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,140,981	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,671,381	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)	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	5,530,400	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,140,981	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	11,671,381	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,433,457			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	25,937,810			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-564,036	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-47,393	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-4,329,105	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CABLE TV	A	-36,302	MAINTENANCE & REPAIRS	6.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	INTEREST INCOME UNRESTRICTED	B	-392,907	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	PAYMENTS FOR EMPLOYEE OUTPATIENT SER	B	-4,516,403	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	NONALLOWABLE BOND EXPENSE	A	-549,834	INTEREST EXPENSE	113.00	0	33.03
33.04	PURCHASE DISCOUNTS	B	-6,815	PURCHASING RECEIVING AND STORES	5.02	0	33.04
33.05	CABLE TV	A	-1,197	SUBPROVIDER - IRF	41.00	0	33.05
33.06	OFFSET OF LOBBYING EXPENSES	A	-23,127	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	LEASEHOLD REVENUE	B	-586,110	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	DEBT FORGIVENESS	A	-61,428	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	REAL ESTATE TAXES	A	-48,633	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
33.10	MEDICAID PROVIDER TAX	A	-6,180,976	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.11	MISCELLANEOUS INCOME	B	-60	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.11
33.12	XRAY FILM REVENUE	B	-463	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	CABLE TV	A	-1,037	CLINIC	90.00	0	33.13
33.14	REAL ESTATE TAXES	A	-117,926	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	2,725	CARDIAC REHABILITATION	76.97	0	33.15
33.16	REAL ESTATE TAXES	A	-8,056	PHYSICAL THERAPY	66.00	0	33.16
33.17	CABLE TV	A	-103	PHYSICAL THERAPY	66.00	0	33.17
33.18	MISCELLANEOUS INCOME	B	-300	DRUGS CHARGED TO PATIENTS	73.00	0	33.18
33.19	QUALITY INCENTIVE PAYMENTS	B	-450	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.19
33.20	DEPARTMENTAL REVENUE	B	-17,250	THERAPY CASH BASED SERVICES	192.02	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,982,833				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: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-1

Date/Time Prepared:
8/23/2021 1:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	397,869	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,495,500	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,379,793	0	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	7,655,491	0	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	2,175,184	0	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	9,050,243	0	4.02
4.03	60.00	LABORATORY	RENT	45,921	69,624	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	RENT	80,726	117,900	4.04
4.05	66.00	PHYSICAL THERAPY	RENT	92,357	169,365	4.05
4.06	69.00	ELECTROCARDIOLOGY	RENT	79,439	157,824	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,452,523	514,713	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	SIMS	100.00	SIMS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	SIHS	100.00	SIHS	100.00	8.00
9.00	B	HSSI	100.00	HSSI	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIH CAYMAN	100.00	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-1

Date/Time Prepared:
8/23/2021 1:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	397,869	9		1.00
2.00	2,495,500	9		2.00
3.00	4,379,793	0		3.00
4.00	7,655,491	0		4.00
4.01	2,175,184	0		4.01
4.02	9,050,243	0		4.02
4.03	-23,703	0		4.03
4.04	-37,174	0		4.04
4.05	-77,008	0		4.05
4.06	-78,385	0		4.06
5.00	25,937,810			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-2

Date/Time Prepared:
8/23/2021 1:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. A	253,704	253,704	0	0	0	1.00
2.00	65.00	DR. B	5,147	0	5,147	179,000	35	2.00
3.00	76.97	DR. C	1,800	0	1,800	179,000	9	3.00
4.00	91.00	DR. D	3,905,564	3,905,564	0	0	0	4.00
5.00	30.00	DR. E	4,603,613	4,603,613	0	0	0	5.00
6.00	41.00	DR. F	1,615,501	1,615,501	0	0	0	6.00
7.00	50.00	DR. G	52,620	15,000	37,620	246,400	182	7.00
8.00	30.00	DR. H	2,975	0	2,975	179,000	8	8.00
9.00	90.00	DR. I	2,120	0	2,120	179,000	15	9.00
10.00	5.04	DR. J	17,739	17,739	0	0	0	10.00
200.00			10,460,783	10,411,121	49,662		249	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	DR. A	0	0	0	0	0	1.00
2.00	65.00	DR. B	3,012	151	0	0	0	2.00
3.00	76.97	DR. C	775	39	0	0	0	3.00
4.00	91.00	DR. D	0	0	0	0	0	4.00
5.00	30.00	DR. E	0	0	0	0	0	5.00
6.00	41.00	DR. F	0	0	0	0	0	6.00
7.00	50.00	DR. G	21,560	1,078	0	0	0	7.00
8.00	30.00	DR. H	688	34	0	0	0	8.00
9.00	90.00	DR. I	1,291	65	0	0	0	9.00
10.00	5.04	DR. J	0	0	0	0	0	10.00
200.00			27,326	1,367	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	DR. A	0	0	0	253,704		1.00
2.00	65.00	DR. B	0	3,012	2,135	2,135		2.00
3.00	76.97	DR. C	0	775	1,025	1,025		3.00
4.00	91.00	DR. D	0	0	0	3,905,564		4.00
5.00	30.00	DR. E	0	0	0	4,603,613		5.00
6.00	41.00	DR. F	0	0	0	1,615,501		6.00
7.00	50.00	DR. G	0	21,560	16,060	31,060		7.00
8.00	30.00	DR. H	0	688	2,287	2,287		8.00
9.00	90.00	DR. I	0	1,291	829	829		9.00
10.00	5.04	DR. J	0	0	0	17,739		10.00
200.00			0	27,326	22,336	10,433,457		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,530,400	5,530,400			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,140,981		6,140,981		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,364,265	39,490	4,637	13,408,392	4.00
5.01	00550	DATA PROCESSING	7,655,491	25,515	0	0	7,681,006
5.02	00560	PURCHASING RECEIVING AND STORES	232,577	45,912	271	55,952	99,636
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,176,321	40,843	4,210	254,292	317,023
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	14,713,519	1,016,401	50,024	966,839	353,254
6.00	00600	MAINTENANCE & REPAIRS	1,767,175	697,334	9,062	159,531	144,925
8.00	00800	LAUNDRY & LINEN SERVICE	759,430	0	582	13,355	9,058
9.00	00900	HOUSEKEEPING	1,644,650	66,948	25,792	333,665	27,173
10.00	01000	DIETARY	751,206	89,658	21,971	113,214	72,462
11.00	01100	CAFETERIA	711,427	101,886	0	192,224	0
13.00	01300	NURSING ADMINISTRATION	1,032,096	24,063	657,559	248,422	45,289
14.00	01400	CENTRAL SERVICES & SUPPLY	250,903	71,623	41,612	54,214	9,058
16.00	01600	MEDICAL RECORDS & LIBRARY	329,872	0	0	96,866	181,156
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,728,970	925,785	262,285	2,671,527	1,367,726
31.00	03100	INTENSIVE CARE UNIT	2,549,147	110,867	116,772	533,508	163,040
41.00	04100	SUBPROVIDER - IRF	3,815,287	424,965	88,342	991,484	788,028
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,378,446	671,451	2,427,311	1,114,742	960,126
51.00	05100	RECOVERY ROOM	782,346	103,363	0	203,215	117,751
53.00	05300	ANESTHESIOLOGY	903,455	689	57,496	180,907	9,058
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,394,188	168,023	667,185	513,753	262,676
56.00	05600	RADIOISOTOPE	895,573	35,356	5,179	54,234	27,173
57.00	05700	CT SCAN	1,228,788	25,096	315,577	137,034	9,058
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	783,566	17,986	204,522	76,695	27,173
60.00	06000	LABORATORY	7,249,260	138,694	305,437	527,955	407,601
65.00	06500	RESPIRATORY THERAPY	1,406,957	63,577	137,564	315,959	199,271
66.00	06600	PHYSICAL THERAPY	7,786,598	193,242	54,624	1,647,933	1,068,819
69.00	06900	ELECTROCARDIOLOGY	1,675,596	66,579	362,908	341,617	262,676
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,357,016	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,051,060	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	8,807,543	46,625	132,181	583,002	153,982
76.97	07697	CARDIAC REHABILITATION	339,086	46,207	33,620	86,326	81,520
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	341,874	0	29,595	69,235	117,751
91.00	09100	EMERGENCY	4,756,833	247,937	119,003	863,753	398,543
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,291,902	5,506,115	6,135,321	13,401,453	7,681,006
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,160	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	260,431	0	5,660	0	0
192.01	19201	OUTREACH LAB	369,054	0	0	0	0
192.02	19202	THERAPY CASH BASED SERVICES	-359,637	0	0	6,939	0
192.03	19203	VACANT SPACE	0	3,125	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	135,561,750	5,530,400	6,140,981	13,408,392	7,681,006

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	434,348					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,155	3,793,844				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	24	0	17,100,061	17,100,061		5.04
6.00	00600	MAINTENANCE & REPAIRS	18	0	2,778,045	399,822	3,177,867	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	782,425	112,608	0	8.00
9.00	00900	HOUSEKEEPING	0	0	2,098,228	301,981	58,051	9.00
10.00	01000	DIETARY	4	0	1,048,515	150,904	77,743	10.00
11.00	01100	CAFETERIA	7	0	1,005,544	144,720	88,346	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,007,429	288,913	20,865	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	427,410	61,514	62,105	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	607,894	87,489	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	99,808	161,636	19,217,737	2,765,912	802,758	30.00
31.00	03100	INTENSIVE CARE UNIT	24,305	21,863	3,519,502	506,534	96,133	31.00
41.00	04100	SUBPROVIDER - IRF	14,754	85,158	6,208,018	893,470	368,490	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	178,822	685,500	14,416,398	2,074,837	582,220	50.00
51.00	05100	RECOVERY ROOM	186	48,037	1,254,898	180,607	89,626	51.00
53.00	05300	ANESTHESIOLOGY	9,408	102,892	1,263,905	181,904	597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,165	189,156	4,198,146	604,206	145,694	54.00
56.00	05600	RADIOISOTOPE	425	76,346	1,094,286	157,492	30,658	56.00
57.00	05700	CT SCAN	6,823	470,565	2,192,941	315,612	21,761	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	454	113,749	1,224,145	176,181	15,596	58.00
60.00	06000	LABORATORY	20,760	628,742	9,278,449	1,335,373	120,263	60.00
65.00	06500	RESPIRATORY THERAPY	7,337	62,592	2,193,257	315,658	55,128	65.00
66.00	06600	PHYSICAL THERAPY	1,468	258,108	11,010,792	1,584,695	167,562	66.00
69.00	06900	ELECTROCARDIOLOGY	2,269	164,965	2,876,610	414,007	57,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	106,343	3,463,359	498,454	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,277	6,166,337	887,472	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	226,275	9,950,398	1,432,081	40,429	73.00
76.97	07697	CARDIAC REHABILITATION	64	6,359	593,182	85,372	40,066	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,639	43,196	603,290	86,827	0	90.00
91.00	09100	EMERGENCY	60,653	227,085	6,673,807	960,508	214,988	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)	434,338	3,793,844	135,255,008	17,005,153	3,156,810	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,160	3,045	18,348	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10	0	266,101	38,298	0	192.00
192.01	19201	OUTREACH LAB	0	0	369,054	53,115	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	-352,698	0	0	192.02
192.03	19203	VACANT SPACE	0	0	3,125	450	2,709	192.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	434,348	3,793,844	135,561,750	17,100,061	3,177,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	895,033					8.00
9.00	00900	HOUSEKEEPING	0	2,458,260				9.00
10.00	01000	DIETARY	0	61,258	1,338,420			10.00
11.00	01100	CAFETERIA	0	69,613	0	1,308,223		11.00
13.00	01300	NURSING ADMINISTRATION	0	16,441	0	28,711	2,362,359	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,936	0	6,266	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	11,195	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	611,060	632,531	913,770	308,766	985,747	30.00
31.00	03100	INTENSIVE CARE UNIT	62,747	75,748	93,831	61,659	151,078	31.00
41.00	04100	SUBPROVIDER - IRF	221,226	290,352	330,819	114,589	403,531	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	458,760	0	128,835	427,057	50.00
51.00	05100	RECOVERY ROOM	0	70,621	0	23,486	55,264	51.00
53.00	05300	ANESTHESIOLOGY	0	471	0	20,908	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,799	0	59,376	0	54.00
56.00	05600	RADIOISOTOPE	0	24,157	0	6,268	0	56.00
57.00	05700	CT SCAN	0	17,147	0	15,837	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,289	0	8,864	0	58.00
60.00	06000	LABORATORY	0	94,761	0	61,018	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,439	0	36,517	0	65.00
66.00	06600	PHYSICAL THERAPY	0	132,030	0	190,458	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	45,489	0	39,482	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,856	0	67,380	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	31,570	0	9,977	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	8,002	0	90.00
91.00	09100	EMERGENCY	0	169,400	0	99,827	339,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	895,033	2,441,668	1,338,420	1,307,421	2,362,359	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,457	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	802	0	192.02
192.03	19203	VACANT SPACE	0	2,135	0	0	0	192.03
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)	895,033	2,458,260	1,338,420	1,308,223	2,362,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	606,231					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	706,578				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,594	30,099	0	26,274,974	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,978	4,071	0	4,576,281	0	31.00
41.00	04100	SUBPROVIDER - IRF	1,125	15,858	0	8,847,478	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	461,265	127,764	0	18,677,136	0	50.00
51.00	05100	RECOVERY ROOM	0	8,945	0	1,683,447	0	51.00
53.00	05300	ANESTHESIOLOGY	7,133	19,160	0	1,494,078	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,260	35,223	0	5,160,704	0	54.00
56.00	05600	RADIOISOTOPE	385	14,217	0	1,327,463	0	56.00
57.00	05700	CT SCAN	0	87,625	0	2,650,923	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5	21,182	0	1,458,262	0	58.00
60.00	06000	LABORATORY	101,770	117,080	0	11,108,714	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,782	11,655	0	2,670,436	0	65.00
66.00	06600	PHYSICAL THERAPY	40	48,063	0	13,133,640	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	30,719	0	3,464,038	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	651	19,802	0	3,982,266	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,466	0	7,075,275	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150	42,135	0	11,564,429	0	73.00
76.97	07697	CARDIAC REHABILITATION	16	1,184	0	761,367	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	44	8,044	0	706,207	0	90.00
91.00	09100	EMERGENCY	4,033	42,286	0	8,504,531	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	606,231	706,578	0	135,121,649	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	57,010	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	304,399	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	422,169	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	-351,896	0	192.02
192.03	19203	VACANT SPACE	0	0	0	8,419	0	192.03
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)	606,231	706,578	0	135,561,750	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	DATA PROCESSING	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OUTREACH LAB	192.01
192.02	19202	THERAPY CASH BASED SERVICES	192.02
192.03	19203	VACANT SPACE	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0011

Period:

From 04/01/2020

To 03/31/2021

Worksheet Non-CMS W

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	DATA PROCESSING	5	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	6	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	9	MEALS SERVED	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	7	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	39,490	4,637	44,127	4.00
5.01	00550	DATA PROCESSING	0	25,515	0	25,515	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	45,912	271	46,183	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	40,843	4,210	45,053	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,016,401	50,024	1,066,425	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	697,334	9,062	706,396	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	582	582	8.00
9.00	00900	HOUSEKEEPING	0	66,948	25,792	92,740	9.00
10.00	01000	DIETARY	0	89,658	21,971	111,629	10.00
11.00	01100	CAFETERIA	0	101,886	0	101,886	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,063	657,559	681,622	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,623	41,612	113,235	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	925,785	262,285	1,188,070	30.00
31.00	03100	INTENSIVE CARE UNIT	0	110,867	116,772	227,639	31.00
41.00	04100	SUBPROVIDER - IRF	0	424,965	88,342	513,307	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	671,451	2,427,311	3,098,762	50.00
51.00	05100	RECOVERY ROOM	0	103,363	0	103,363	51.00
53.00	05300	ANESTHESIOLOGY	0	689	57,496	58,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	168,023	667,185	835,208	54.00
56.00	05600	RADIOISOTOPE	0	35,356	5,179	40,535	56.00
57.00	05700	CT SCAN	0	25,096	315,577	340,673	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,986	204,522	222,508	58.00
60.00	06000	LABORATORY	0	138,694	305,437	444,131	60.00
65.00	06500	RESPIRATORY THERAPY	0	63,577	137,564	201,141	65.00
66.00	06600	PHYSICAL THERAPY	0	193,242	54,624	247,866	66.00
69.00	06900	ELECTROCARDIOLOGY	0	66,579	362,908	429,487	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	46,625	132,181	178,806	73.00
76.97	07697	CARDIAC REHABILITATION	0	46,207	33,620	79,827	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	29,595	29,595	90.00
91.00	09100	EMERGENCY	0	247,937	119,003	366,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,506,115	6,135,321	11,641,436	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,160	0	21,160	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,660	5,660	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	0	192.02
192.03	19203	VACANT SPACE	0	3,125	0	3,125	192.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,530,400	6,140,981	11,671,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	25,515					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	331	46,698				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,053	124	47,066			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,173	3	0	1,070,781		5.04
6.00	00600	MAINTENANCE & REPAIRS	481	2	0	25,036	732,440	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	30	0	0	7,051	0	8.00
9.00	00900	HOUSEKEEPING	90	0	0	18,909	13,380	9.00
10.00	01000	DIETARY	241	0	0	9,449	17,918	10.00
11.00	01100	CAFETERIA	0	1	0	9,062	20,362	11.00
13.00	01300	NURSING ADMINISTRATION	150	0	0	18,091	4,809	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30	0	0	3,852	14,314	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	602	0	0	5,478	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,544	10,731	1,997	173,215	185,021	30.00
31.00	03100	INTENSIVE CARE UNIT	542	2,613	270	31,718	22,157	31.00
41.00	04100	SUBPROVIDER - IRF	2,618	1,586	1,052	55,947	84,930	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,189	19,224	8,663	129,921	134,191	50.00
51.00	05100	RECOVERY ROOM	391	20	593	11,309	20,657	51.00
53.00	05300	ANESTHESIOLOGY	30	1,012	1,271	11,390	138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	873	340	2,337	37,834	33,580	54.00
56.00	05600	RADIOISOTOPE	90	46	943	9,862	7,066	56.00
57.00	05700	CT SCAN	30	734	5,814	19,763	5,016	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	90	49	1,405	11,032	3,594	58.00
60.00	06000	LABORATORY	1,354	2,232	7,768	83,617	27,718	60.00
65.00	06500	RESPIRATORY THERAPY	662	789	773	19,766	12,706	65.00
66.00	06600	PHYSICAL THERAPY	3,550	158	3,189	99,229	38,620	66.00
69.00	06900	ELECTROCARDIOLOGY	873	244	2,038	25,924	13,306	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,314	31,212	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,424	55,571	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	512	85	2,796	89,673	9,318	73.00
76.97	07697	CARDIAC REHABILITATION	271	7	79	5,346	9,235	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	391	176	534	5,437	0	90.00
91.00	09100	EMERGENCY	1,324	6,521	2,806	60,144	49,551	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)	25,515	46,697	47,066	1,064,838	727,587	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	191	4,229	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1	0	2,398	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	3,326	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	0	0	192.02
192.03	19203	VACANT SPACE	0	0	0	28	624	192.03
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)	25,515	46,698	47,066	1,070,781	732,440	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,707					8.00
9.00	00900	HOUSEKEEPING	0	126,217				9.00
10.00	01000	DIETARY	0	3,145	142,754			10.00
11.00	01100	CAFETERIA	0	3,574	0	135,517		11.00
13.00	01300	NURSING ADMINISTRATION	0	844	0	2,974	709,307	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,513	0	649	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,160	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,262	32,477	97,461	31,997	295,974	30.00
31.00	03100	INTENSIVE CARE UNIT	540	3,889	10,008	6,386	45,362	31.00
41.00	04100	SUBPROVIDER - IRF	1,905	14,908	35,285	11,869	121,162	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	23,555	0	13,344	128,225	50.00
51.00	05100	RECOVERY ROOM	0	3,626	0	2,433	16,593	51.00
53.00	05300	ANESTHESIOLOGY	0	24	0	2,166	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,894	0	6,150	0	54.00
56.00	05600	RADIOISOTOPE	0	1,240	0	649	0	56.00
57.00	05700	CT SCAN	0	880	0	1,640	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	631	0	918	0	58.00
60.00	06000	LABORATORY	0	4,865	0	6,320	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,230	0	3,782	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,779	0	19,727	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,336	0	4,089	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,636	0	6,979	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,621	0	1,033	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	829	0	90.00
91.00	09100	EMERGENCY	0	8,698	0	10,340	101,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,707	125,365	142,754	135,434	709,307	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	742	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	0	83	0	192.02
192.03	19203	VACANT SPACE	0	110	0	0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,707	126,217	142,754	135,517	709,307	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	134,771					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,559				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,466	318		2,037,343	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,107	43		354,029	0	31.00
41.00	04100	SUBPROVIDER - IRF	250	168		848,248	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	102,542	1,437		3,666,720	0	50.00
51.00	05100	RECOVERY ROOM	0	95		159,748	0	51.00
53.00	05300	ANESTHESIOLOGY	1,586	203		76,600	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725	373		925,004	0	54.00
56.00	05600	RADIOISOTOPE	86	150		60,845	0	56.00
57.00	05700	CT SCAN	0	927		375,928	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1	224		240,704	0	58.00
60.00	06000	LABORATORY	22,624	1,238		603,604	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,286	123		246,297	0	65.00
66.00	06600	PHYSICAL THERAPY	9	508		425,056	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	325		479,746	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145	209		32,880	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	227		57,222	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33	446		292,202	0	73.00
76.97	07697	CARDIAC REHABILITATION	4	13		97,720	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10	85		37,285	0	90.00
91.00	09100	EMERGENCY	897	447		612,500	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,771	7,559	0	11,629,681	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		26,322	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		8,059	0	192.00
192.01	19201	OUTREACH LAB	0	0		3,326	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0		106	0	192.02
192.03	19203	VACANT SPACE	0	0		3,887	0	192.03
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)	134,771	7,559	0	11,671,381	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	DATA PROCESSING	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OUTREACH LAB	192.01
192.02	19202	THERAPY CASH BASED SERVICES	192.02
192.03	19203	VACANT SPACE	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,774				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,333,335			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,605	2,517	51,165,662		4.00
5.01	00550	DATA PROCESSING	1,037	0	0	848	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,866	147	213,509	11	8,115,734
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,660	2,285	970,366	35	21,576
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	41,310	27,153	3,689,407	39	442
6.00	00600	MAINTENANCE & REPAIRS	28,342	4,919	608,764	16	328
8.00	00800	LAUNDRY & LINEN SERVICE	0	316	50,961	1	0
9.00	00900	HOUSEKEEPING	2,721	14,000	1,273,248	3	0
10.00	01000	DIETARY	3,644	11,926	432,018	8	76
11.00	01100	CAFETERIA	4,141	0	733,518	0	130
13.00	01300	NURSING ADMINISTRATION	978	356,924	947,965	5	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,911	22,587	206,876	1	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	369,635	20	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,627	142,369	10,194,345	151	1,864,915
31.00	03100	INTENSIVE CARE UNIT	4,506	63,384	2,035,840	18	454,139
41.00	04100	SUBPROVIDER - IRF	17,272	47,952	3,783,454	87	275,684
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,290	1,317,549	4,253,798	106	3,341,236
51.00	05100	RECOVERY ROOM	4,201	0	775,457	13	3,482
53.00	05300	ANESTHESIOLOGY	28	31,209	690,333	1	175,795
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,829	362,149	1,960,457	29	59,131
56.00	05600	RADIOISOTOPE	1,437	2,811	206,953	3	7,934
57.00	05700	CT SCAN	1,020	171,296	522,913	1	127,494
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	111,015	292,663	3	8,485
60.00	06000	LABORATORY	5,637	165,792	2,014,649	45	387,905
65.00	06500	RESPIRATORY THERAPY	2,584	74,670	1,205,683	22	137,093
66.00	06600	PHYSICAL THERAPY	7,854	29,650	6,288,427	118	27,430
69.00	06900	ELECTROCARDIOLOGY	2,706	196,987	1,303,592	29	42,387
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,895	71,748	2,224,706	17	14,768
76.97	07697	CARDIAC REHABILITATION	1,878	18,249	329,414	9	1,187
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	16,064	264,196	13	30,631
91.00	09100	EMERGENCY	10,077	64,595	3,296,037	44	1,133,300
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,787	3,330,263	51,139,184	848	8,115,548
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,072	0	0	186
192.01	19201	OUTREACH LAB	0	0	0	0	0
192.02	19202	THERAPY CASH BASED SERVICES	0	0	26,478	0	0
192.03	19203	VACANT SPACE	127	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	5,530,400	6,140,981	13,408,392	7,681,006	434,348
203.00		Unit cost multiplier (Wkst. B, Part I)	24.604269	1.842293	0.262058	9,057.790094	0.053519
204.00		Cost to be allocated (per Wkst. B, Part II)			44,127	25,515	46,698
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000862	30.088443	0.005754
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.03	5A.04	5.04	6.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	679,320,603					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-17,100,061	118,814,387			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,778,045	148,954		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	782,425	0	31,638	8.00
9.00	00900	HOUSEKEEPING	0	0	2,098,228	2,721	0	9.00
10.00	01000	DIETARY	0	0	1,048,515	3,644	0	10.00
11.00	01100	CAFETERIA	0	0	1,005,544	4,141	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,007,429	978	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	427,410	2,911	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	607,894	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,941,050	0	19,217,737	37,627	21,600	30.00
31.00	03100	INTENSIVE CARE UNIT	3,914,532	0	3,519,502	4,506	2,218	31.00
41.00	04100	SUBPROVIDER - IRF	15,247,704	0	6,208,018	17,272	7,820	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	122,768,657	0	14,416,398	27,290	0	50.00
51.00	05100	RECOVERY ROOM	8,601,117	0	1,254,898	4,201	0	51.00
53.00	05300	ANESTHESIOLOGY	18,422,872	0	1,263,905	28	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,868,589	0	4,198,146	6,829	0	54.00
56.00	05600	RADIOISOTOPE	13,669,755	0	1,094,286	1,437	0	56.00
57.00	05700	CT SCAN	84,255,215	0	2,192,941	1,020	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,366,844	0	1,224,145	731	0	58.00
60.00	06000	LABORATORY	112,576,932	0	9,278,449	5,637	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,207,082	0	2,193,257	2,584	0	65.00
66.00	06600	PHYSICAL THERAPY	46,214,470	0	11,010,792	7,854	0	66.00
69.00	06900	ELECTROCARDIOLOGY	29,537,125	0	2,876,610	2,706	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,040,753	0	3,463,359	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,640,513	0	6,166,337	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,514,836	0	9,950,398	1,895	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,138,548	0	593,182	1,878	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,734,254	0	603,290	0	0	90.00
91.00	09100	EMERGENCY	40,659,755	0	6,673,807	10,077	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)	679,320,603	-17,100,061	118,154,947	147,967	31,638	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21,160	860	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	266,101	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	369,054	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	352,698	0	0	0	192.02
192.03	19203	VACANT SPACE	0	0	3,125	127	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,793,844		17,100,061	3,177,867	895,033	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005585		0.143922	21.334553	28.289810	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,066		1,070,781	732,440	7,707	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000069		0.009012	4.917223	0.243599	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	146,233					9.00
10.00	01000	DIETARY	3,644	94,914				10.00
11.00	01100	CAFETERIA	4,141	0	43,193,871			11.00
13.00	01300	NURSING ADMINISTRATION	978	0	947,965	680,523		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,911	0	206,876	0	3,810,509	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	369,635	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,627	64,800	10,194,345	283,963	41,449	30.00
31.00	03100	INTENSIVE CARE UNIT	4,506	6,654	2,035,840	43,521	31,291	31.00
41.00	04100	SUBPROVIDER - IRF	17,272	23,460	3,783,454	116,245	7,073	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,290	0	4,253,798	123,022	2,899,307	50.00
51.00	05100	RECOVERY ROOM	4,201	0	775,457	15,920	0	51.00
53.00	05300	ANESTHESIOLOGY	28	0	690,333	0	44,836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,829	0	1,960,457	0	20,494	54.00
56.00	05600	RADIOISOTOPE	1,437	0	206,953	0	2,423	56.00
57.00	05700	CT SCAN	1,020	0	522,913	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731	0	292,663	731	30	58.00
60.00	06000	LABORATORY	5,637	0	2,014,649	0	639,685	60.00
65.00	06500	RESPIRATORY THERAPY	2,584	0	1,205,683	0	92,913	65.00
66.00	06600	PHYSICAL THERAPY	7,854	0	6,288,427	0	249	66.00
69.00	06900	ELECTROCARDIOLOGY	2,706	0	1,303,592	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,895	0	2,224,706	0	940	73.00
76.97	07697	CARDIAC REHABILITATION	1,878	0	329,414	0	100	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	264,196	0	276	90.00
91.00	09100	EMERGENCY	10,077	0	3,296,037	97,852	25,349	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)	145,246	94,914	43,167,393	680,523	3,810,509	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	860	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	0	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	26,478	0	0	192.02
192.03	19203	VACANT SPACE	127	0	0	0	0	192.03
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)	2,458,260	1,338,420	1,308,223	2,362,359	606,231	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.810569	14.101397	0.030287	3.471387	0.159094	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	126,217	142,754	135,517	709,307	134,771	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.863123	1.504035	0.003137	1.042297	0.035368	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet B-1
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00560	PURCHASING RECEIVING AND STORES			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY	679,320,603		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	28,941,050	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,914,532	0	31.00
41.00	04100	SUBPROVIDER - IRF	15,247,704	0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	122,768,657	0	50.00
51.00	05100	RECOVERY ROOM	8,601,117	0	51.00
53.00	05300	ANESTHESIOLOGY	18,422,872	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,868,589	0	54.00
56.00	05600	RADIOISOTOPE	13,669,755	0	56.00
57.00	05700	CT SCAN	84,255,215	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,366,844	0	58.00
60.00	06000	LABORATORY	112,576,932	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,207,082	0	65.00
66.00	06600	PHYSICAL THERAPY	46,214,470	0	66.00
69.00	06900	ELECTROCARDIOLOGY	29,537,125	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,040,753	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,640,513	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,514,836	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,138,548	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7,734,254	0	90.00
91.00	09100	EMERGENCY	40,659,755	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)	679,320,603	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	OUTREACH LAB	0	0	192.01
192.02	19202	THERAPY CASH BASED SERVICES	0	0	192.02
192.03	19203	VACANT SPACE	0	0	192.03
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)	706,578	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001040	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,559	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000011	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

			Title XVIII	Hospital	PPS			
Cost Center Description			Therapy Limit Adj.	Costs				
				Total Costs	RCE		Total Costs	
					Disallowance			
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,274,974		26,274,974	2,287	26,277,261	30.00
31.00	03100	INTENSIVE CARE UNIT	4,576,281		4,576,281	0	4,576,281	31.00
41.00	04100	SUBPROVIDER - IRF	8,847,478		8,847,478	0	8,847,478	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,677,136		18,677,136	16,060	18,693,196	50.00
51.00	05100	RECOVERY ROOM	1,683,447		1,683,447	0	1,683,447	51.00
53.00	05300	ANESTHESIOLOGY	1,494,078		1,494,078	0	1,494,078	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160,704		5,160,704	0	5,160,704	54.00
56.00	05600	RADIOISOTOPE	1,327,463		1,327,463	0	1,327,463	56.00
57.00	05700	CT SCAN	2,650,923		2,650,923	0	2,650,923	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,458,262		1,458,262	0	1,458,262	58.00
60.00	06000	LABORATORY	11,108,714		11,108,714	0	11,108,714	60.00
65.00	06500	RESPIRATORY THERAPY	2,670,436	0	2,670,436	2,135	2,672,571	65.00
66.00	06600	PHYSICAL THERAPY	13,133,640	0	13,133,640	0	13,133,640	66.00
69.00	06900	ELECTROCARDIOLOGY	3,464,038		3,464,038	0	3,464,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,982,266		3,982,266	0	3,982,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,075,275		7,075,275	0	7,075,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,564,429		11,564,429	0	11,564,429	73.00
76.97	07697	CARDIAC REHABILITATION	761,367		761,367	1,025	762,392	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	706,207		706,207	829	707,036	90.00
91.00	09100	EMERGENCY	8,504,531		8,504,531	0	8,504,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,832,238		1,832,238		1,832,238	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	136,953,887	0	136,953,887	22,336	136,976,223	200.00
201.00		Less Observation Beds	1,832,238		1,832,238		1,832,238	201.00
202.00		Total (see instructions)	135,121,649	0	135,121,649	22,336	135,143,985	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,805,548		24,805,548			30.00
31.00	03100	INTENSIVE CARE UNIT	3,914,532		3,914,532			31.00
41.00	04100	SUBPROVIDER - IRF	13,992,792		13,992,792			41.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	40,702,636	79,290,624	119,993,260	0.155652	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,618,199	4,359,823	7,978,022	0.211011	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	6,103,621	11,837,109	17,940,730	0.083279	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,428,951	27,490,912	32,919,863	0.156766	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,716,552	10,757,812	13,474,364	0.098518	0.000000	56.00
57.00	05700	CT SCAN	24,266,720	58,806,310	83,073,030	0.031911	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,502,737	15,212,029	19,714,766	0.073968	0.000000	58.00
60.00	06000	LABORATORY	29,570,353	80,496,342	110,066,695	0.100927	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,002,179	2,166,240	11,168,419	0.239106	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	18,692,782	26,284,998	44,977,780	0.292003	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,006,954	19,280,366	29,287,320	0.118278	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,149,817	9,545,221	18,695,038	0.213012	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,085,343	8,242,217	20,327,560	0.348063	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,821,797	12,400,775	40,222,572	0.287511	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,559	1,124,491	1,126,050	0.676140	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	153,962	7,570,126	7,724,088	0.091429	0.000000	90.00
91.00	09100	EMERGENCY	11,816,650	28,274,244	40,090,894	0.212131	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	749,771	3,290,730	4,040,501	0.453468	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	259,103,455	406,430,369	665,533,824			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	259,103,455	406,430,369	665,533,824			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.155785			50.00
51.00	05100	RECOVERY ROOM	0.211011			51.00
53.00	05300	ANESTHESIOLOGY	0.083279			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156766			54.00
56.00	05600	RADIOISOTOPE	0.098518			56.00
57.00	05700	CT SCAN	0.031911			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.073968			58.00
60.00	06000	LABORATORY	0.100927			60.00
65.00	06500	RESPIRATORY THERAPY	0.239297			65.00
66.00	06600	PHYSICAL THERAPY	0.292003			66.00
69.00	06900	ELECTROCARDIOLOGY	0.118278			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213012			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.348063			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287511			73.00
76.97	07697	CARDIAC REHABILITATION	0.677050			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.091537			90.00
91.00	09100	EMERGENCY	0.212131			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.453468			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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

			Title XIX		Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,274,974		26,274,974	2,287	26,277,261	30.00
31.00	03100	INTENSIVE CARE UNIT	4,576,281		4,576,281	0	4,576,281	31.00
41.00	04100	SUBPROVIDER - IRF	8,847,478		8,847,478	0	8,847,478	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,677,136		18,677,136	16,060	18,693,196	50.00
51.00	05100	RECOVERY ROOM	1,683,447		1,683,447	0	1,683,447	51.00
53.00	05300	ANESTHESIOLOGY	1,494,078		1,494,078	0	1,494,078	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160,704		5,160,704	0	5,160,704	54.00
56.00	05600	RADIOISOTOPE	1,327,463		1,327,463	0	1,327,463	56.00
57.00	05700	CT SCAN	2,650,923		2,650,923	0	2,650,923	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,458,262		1,458,262	0	1,458,262	58.00
60.00	06000	LABORATORY	11,108,714		11,108,714	0	11,108,714	60.00
65.00	06500	RESPIRATORY THERAPY	2,670,436	0	2,670,436	2,135	2,672,571	65.00
66.00	06600	PHYSICAL THERAPY	13,133,640	0	13,133,640	0	13,133,640	66.00
69.00	06900	ELECTROCARDIOLOGY	3,464,038		3,464,038	0	3,464,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,982,266		3,982,266	0	3,982,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,075,275		7,075,275	0	7,075,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,564,429		11,564,429	0	11,564,429	73.00
76.97	07697	CARDIAC REHABILITATION	761,367		761,367	1,025	762,392	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	706,207		706,207	829	707,036	90.00
91.00	09100	EMERGENCY	8,504,531		8,504,531	0	8,504,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,832,238		1,832,238		1,832,238	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	136,953,887	0	136,953,887	22,336	136,976,223	200.00
201.00		Less Observation Beds	1,832,238		1,832,238		1,832,238	201.00
202.00		Total (see instructions)	135,121,649	0	135,121,649	22,336	135,143,985	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
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			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	24,805,548		24,805,548		30.00
31.00	03100	INTENSIVE CARE UNIT	3,914,532		3,914,532		31.00
41.00	04100	SUBPROVIDER - IRF	13,992,792		13,992,792		41.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,702,636	79,290,624	119,993,260	0.155652	0.000000
51.00	05100	RECOVERY ROOM	3,618,199	4,359,823	7,978,022	0.211011	0.000000
53.00	05300	ANESTHESIOLOGY	6,103,621	11,837,109	17,940,730	0.083279	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,428,951	27,490,912	32,919,863	0.156766	0.000000
56.00	05600	RADIOISOTOPE	2,716,552	10,757,812	13,474,364	0.098518	0.000000
57.00	05700	CT SCAN	24,266,720	58,806,310	83,073,030	0.031911	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,502,737	15,212,029	19,714,766	0.073968	0.000000
60.00	06000	LABORATORY	29,570,353	80,496,342	110,066,695	0.100927	0.000000
65.00	06500	RESPIRATORY THERAPY	9,002,179	2,166,240	11,168,419	0.239106	0.000000
66.00	06600	PHYSICAL THERAPY	18,692,782	26,284,998	44,977,780	0.292003	0.000000
69.00	06900	ELECTROCARDIOLOGY	10,006,954	19,280,366	29,287,320	0.118278	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,149,817	9,545,221	18,695,038	0.213012	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,085,343	8,242,217	20,327,560	0.348063	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	27,821,797	12,400,775	40,222,572	0.287511	0.000000
76.97	07697	CARDIAC REHABILITATION	1,559	1,124,491	1,126,050	0.676140	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	153,962	7,570,126	7,724,088	0.091429	0.000000
91.00	09100	EMERGENCY	11,816,650	28,274,244	40,090,894	0.212131	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	749,771	3,290,730	4,040,501	0.453468	0.000000
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	259,103,455	406,430,369	665,533,824		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	259,103,455	406,430,369	665,533,824		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
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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
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,037,343	0	2,037,343	23,219	87.74	30.00
31.00	INTENSIVE CARE UNIT	354,029		354,029	2,218	159.62	31.00
41.00	SUBPROVIDER - IRF	848,248	0	848,248	7,820	108.47	41.00
200.00	Total (lines 30 through 199)	3,239,620		3,239,620	33,257		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	12,198	1,070,253				30.00
31.00	INTENSIVE CARE UNIT	1,338	213,572				31.00
41.00	SUBPROVIDER - IRF	4,906	532,154				41.00
200.00	Total (lines 30 through 199)	18,442	1,815,979				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part II
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,666,720	119,993,260	0.030558	19,990,544	610,871
51.00	05100	RECOVERY ROOM	159,748	7,978,022	0.020024	1,739,039	34,823
53.00	05300	ANESTHESIOLOGY	76,600	17,940,730	0.004270	2,912,673	12,437
54.00	05400	RADIOLOGY-DIAGNOSTIC	925,004	32,919,863	0.028099	2,677,369	75,231
56.00	05600	RADIOISOTOPE	60,845	13,474,364	0.004516	1,499,262	6,771
57.00	05700	CT SCAN	375,928	83,073,030	0.004525	12,728,001	57,594
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	240,704	19,714,766	0.012209	2,076,191	25,348
60.00	06000	LABORATORY	603,604	110,066,695	0.005484	15,991,008	87,695
65.00	06500	RESPIRATORY THERAPY	246,297	11,168,419	0.022053	4,755,055	104,863
66.00	06600	PHYSICAL THERAPY	425,056	44,977,780	0.009450	4,167,363	39,382
69.00	06900	ELECTROCARDIOLOGY	479,746	29,287,320	0.016381	5,791,479	94,870
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,880	18,695,038	0.001759	3,770,917	6,633
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,222	20,327,560	0.002815	7,103,212	19,996
73.00	07300	DRUGS CHARGED TO PATIENTS	292,202	40,222,572	0.007265	13,698,899	99,523
76.97	07697	CARDIAC REHABILITATION	97,720	1,126,050	0.086781	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	37,285	7,724,088	0.004827	151,592	732
91.00	09100	EMERGENCY	612,500	40,090,894	0.015278	6,288,046	96,069
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,059	4,040,501	0.035159	433,622	15,246
200.00		Total (lines 50 through 199)	8,532,120	622,820,952		105,774,272	1,388,084

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0011		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part III Date/Time Prepared: 8/23/2021 1:52 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	23,219	0.00	12,198		30.00
31.00	03100	INTENSIVE CARE UNIT			0	2,218	0.00	1,338		31.00
41.00	04100	SUBPROVIDER - IRF		0	0	7,820	0.00	4,906		41.00
200.00		Total (lines 30 through 199)			0	33,257		18,442		200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0					30.00
31.00	03100	INTENSIVE CARE UNIT		0	0					31.00
41.00	04100	SUBPROVIDER - IRF		0	0					41.00
200.00		Total (lines 30 through 199)		0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
60.00	06000	LABORATORY	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 1:52 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	119,993,260	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,978,022	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,940,730	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,919,863	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	13,474,364	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	83,073,030	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,714,766	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	110,066,695	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,168,419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	44,977,780	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,287,320	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,695,038	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,327,560	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,222,572	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,126,050	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,724,088	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,090,894	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,040,501	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	622,820,952		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	19,990,544	0	22,676,475	0
51.00	05100	RECOVERY ROOM	0.000000	1,739,039	0	1,469,969	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,912,673	0	3,516,180	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,677,369	0	9,883,682	0
56.00	05600	RADIOISOTOPE	0.000000	1,499,262	0	5,206,103	0
57.00	05700	CT SCAN	0.000000	12,728,001	0	23,474,037	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,076,191	0	5,134,055	0
60.00	06000	LABORATORY	0.000000	15,991,008	0	8,948,644	0
65.00	06500	RESPIRATORY THERAPY	0.000000	4,755,055	0	771,863	0
66.00	06600	PHYSICAL THERAPY	0.000000	4,167,363	0	38,753	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,791,479	0	5,681,757	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,770,917	0	3,013,702	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,103,212	0	2,689,150	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	13,698,899	0	3,758,982	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	363,948	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	151,592	0	4,081,531	0
91.00	09100	EMERGENCY	0.000000	6,288,046	0	7,939,784	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	433,622	0	1,204,259	0
200.00		Total (lines 50 through 199)		105,774,272	0	109,852,874	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/23/2021 1:52 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
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
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Total (lines 50 through 199)	0	0					200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/23/2021 1:52 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.155652	22,676,475	0	0	3,529,639	50.00	
51.00	05100	RECOVERY ROOM	0.211011	1,469,969	0	0	310,180	51.00	
53.00	05300	ANESTHESIOLOGY	0.083279	3,516,180	0	0	292,824	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156766	9,883,682	0	0	1,549,425	54.00	
56.00	05600	RADIOISOTOPE	0.098518	5,206,103	0	0	512,895	56.00	
57.00	05700	CT SCAN	0.031911	23,474,037	0	0	749,080	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.073968	5,134,055	0	0	379,756	58.00	
60.00	06000	LABORATORY	0.100927	8,948,644	36,680	0	903,160	60.00	
65.00	06500	RESPIRATORY THERAPY	0.239106	771,863	0	0	184,557	65.00	
66.00	06600	PHYSICAL THERAPY	0.292003	38,753	0	0	11,316	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.118278	5,681,757	0	0	672,027	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213012	3,013,702	0	0	641,955	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.348063	2,689,150	0	0	935,994	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287511	3,758,982	212	44,909	1,080,749	73.00	
76.97	07697	CARDIAC REHABILITATION	0.676140	363,948	0	0	246,080	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.091429	4,081,531	0	0	373,170	90.00	
91.00	09100	EMERGENCY	0.212131	7,939,784	0	0	1,684,274	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.453468	1,204,259	0	0	546,093	92.00	
200.00		Subtotal (see instructions)		109,852,874	36,892	44,909	14,603,174	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		109,852,874	36,892	44,909	14,603,174	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0011		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part V Date/Time Prepared: 8/23/2021 1:52 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
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
60.00	06000	LABORATORY	3,702	0					60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61	12,912					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
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)	3,763	12,912					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	3,763	12,912					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2020 To 03/31/2021	Worksheet D Part II Date/Time Prepared: 8/23/2021 1:52 pm		
				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	3,666,720	119,993,260	0.030558	91,710	2,802	50.00
51.00	05100	RECOVERY ROOM	159,748	7,978,022	0.020024	6,260	125	51.00
53.00	05300	ANESTHESIOLOGY	76,600	17,940,730	0.004270	10,698	46	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	925,004	32,919,863	0.028099	153,616	4,316	54.00
56.00	05600	RADIOISOTOPE	60,845	13,474,364	0.004516	42,120	190	56.00
57.00	05700	CT SCAN	375,928	83,073,030	0.004525	299,702	1,356	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	240,704	19,714,766	0.012209	74,937	915	58.00
60.00	06000	LABORATORY	603,604	110,066,695	0.005484	826,146	4,531	60.00
65.00	06500	RESPIRATORY THERAPY	246,297	11,168,419	0.022053	644,661	14,217	65.00
66.00	06600	PHYSICAL THERAPY	425,056	44,977,780	0.009450	7,691,472	72,684	66.00
69.00	06900	ELECTROCARDIOLOGY	479,746	29,287,320	0.016381	79,158	1,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,880	18,695,038	0.001759	33,260	59	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,222	20,327,560	0.002815	8,750	25	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	292,202	40,222,572	0.007265	1,608,315	11,684	73.00
76.97	07697	CARDIAC REHABILITATION	97,720	1,126,050	0.086781	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	37,285	7,724,088	0.004827	2,370	11	90.00
91.00	09100	EMERGENCY	612,500	40,090,894	0.015278	2,710	41	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,040,501	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,390,061	622,820,952		11,575,885	114,299	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/23/2021 1:52 pm	
				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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
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
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/23/2021 1:52 pm	
			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	119,993,260	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,978,022	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,940,730	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,919,863	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	13,474,364	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	83,073,030	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,714,766	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	110,066,695	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,168,419	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	44,977,780	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,287,320	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,695,038	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,327,560	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,222,572	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,126,050	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,724,088	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,090,894	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,040,501	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	622,820,952		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/23/2021 1:52 pm	
				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		91,710	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		6,260	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000		10,698	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		153,616	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000		42,120	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		299,702	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		74,937	0	0	0	58.00
60.00	06000	LABORATORY	0.000000		826,146	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		644,661	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		7,691,472	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		79,158	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		33,260	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		8,750	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,608,315	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		2,370	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000		2,710	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)			11,575,885	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/23/2021 1:52 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
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
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
200.00		Total (lines 50 through 199)	0	0					200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/23/2021 1:52 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,219	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,219	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)	21,600	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)	12,198	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)	26,277,261	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)	26,277,261	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)	26,277,261	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)	1,131.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,804,599	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)	13,804,599	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/23/2021 1:52 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,576,281	2,218	2,063.25	1,338	2,760,629
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					18,263,186
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					34,828,414
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,283,825
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,388,084
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,671,909
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					32,156,505
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)					1,619
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,131.71
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,832,238

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
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			Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,037,343	26,277,261	0.077533	1,832,238	142,059	90.00
91.00	Nursing School cost	0	26,277,261	0.000000	1,832,238	0	91.00
92.00	Allied health cost	0	26,277,261	0.000000	1,832,238	0	92.00
93.00	All other Medical Education	0	26,277,261	0.000000	1,832,238	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/23/2021 1:52 pm
		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)		7,820	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,820	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)		7,820	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)		4,906	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)		8,847,478	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)		8,847,478	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)		8,847,478	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)		1,131.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,550,599	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)		5,550,599	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0011

Period:

Worksheet D-1

Component CCN: 14-T011

From 04/01/2020
To 03/31/2021Date/Time Prepared:
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		Title XVIII		Subprovider - IRF	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)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,026,110
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,576,709
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					532,154
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					114,299
52.00	Total Program excludable cost (sum of lines 50 and 51)					646,453
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,930,256
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)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0011 Component CCN: 14-T011		Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/23/2021 1:52 pm	
			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	848,248	8,847,478	0.095875	0	0	90.00
91.00	Nursing School cost	0	8,847,478	0.000000	0	0	91.00
92.00	Allied health cost	0	8,847,478	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,847,478	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/23/2021 1:52 pm
			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		12,374,778	30.00
31.00	03100	INTENSIVE CARE UNIT		2,176,290	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.155785	19,990,544	50.00
51.00	05100	RECOVERY ROOM	0.211011	1,739,039	51.00
53.00	05300	ANESTHESIOLOGY	0.083279	2,912,673	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156766	2,677,369	54.00
56.00	05600	RADIOISOTOPE	0.098518	1,499,262	56.00
57.00	05700	CT SCAN	0.031911	12,728,001	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.073968	2,076,191	58.00
60.00	06000	LABORATORY	0.100927	15,991,008	60.00
65.00	06500	RESPIRATORY THERAPY	0.239297	4,755,055	65.00
66.00	06600	PHYSICAL THERAPY	0.292003	4,167,363	66.00
69.00	06900	ELECTROCARDIOLOGY	0.118278	5,791,479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213012	3,770,917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.348063	7,103,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287511	13,698,899	73.00
76.97	07697	CARDIAC REHABILITATION	0.677050	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.091537	151,592	90.00
91.00	09100	EMERGENCY	0.212131	6,288,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.453468	433,622	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		105,774,272	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)		105,774,272	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/23/2021 1:52 pm	
		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		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		8,956,872		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.155785	91,710	14,287	50.00
51.00	05100 RECOVERY ROOM	0.211011	6,260	1,321	51.00
53.00	05300 ANESTHESIOLOGY	0.083279	10,698	891	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156766	153,616	24,082	54.00
56.00	05600 RADIOISOTOPE	0.098518	42,120	4,150	56.00
57.00	05700 CT SCAN	0.031911	299,702	9,564	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.073968	74,937	5,543	58.00
60.00	06000 LABORATORY	0.100927	826,146	83,380	60.00
65.00	06500 RESPIRATORY THERAPY	0.239297	644,661	154,265	65.00
66.00	06600 PHYSICAL THERAPY	0.292003	7,691,472	2,245,933	66.00
69.00	06900 ELECTROCARDIOLOGY	0.118278	79,158	9,363	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.213012	33,260	7,085	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.348063	8,750	3,046	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.287511	1,608,315	462,408	73.00
76.97	07697 CARDIAC REHABILITATION	0.677050	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.091537	2,370	217	90.00
91.00	09100 EMERGENCY	0.212131	2,710	575	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.453468	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		11,575,885	3,026,110	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)		11,575,885		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A
Date/Time Prepared:
8/23/2021 1:52 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			10,791,712	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			13,316,625	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			81,922	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			308,824	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			80.56	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.24	30.00
31.00	Percentage of Medicaid patient days (see instructions)			16.15	31.00
32.00	Sum of lines 30 and 31			21.39	32.00
33.00	Allowable disproportionate share percentage (see instructions)			6.86	33.00
34.00	Disproportionate share adjustment (see instructions)			413,458	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part A Date/Time Prepared: 8/23/2021 1:52 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,313,512	1,028,231		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	656,756	512,707		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,169,463			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 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	26,082,004			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	29,482,025			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			28,632,020	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,875,204	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			30,507,224	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			30,507,224	61.00
62.00	Deductibles billed to program beneficiaries			2,832,044	62.00
63.00	Coinsurance billed to program beneficiaries			117,423	63.00
64.00	Allowable bad debts (see instructions)			1,259,197	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			818,478	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			729,158	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			28,376,235	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)			-19,590	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-56,628	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-182,320	70.93
70.94	HRR adjustment amount (see instructions)			-531,142	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part A Date/Time Prepared: 8/23/2021 1:52 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		166,584	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		27,419,971	71.00
71.01	Sequestration adjustment (see instructions)		43,872	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		34,880,056	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)		-7,503,957	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		50,954	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)		1,278,501	1,271,515
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		0.9909299020	0.9937128833
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		-11,596	-7,994
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9753	0.9803
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-31,579	-25,049
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.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			
202.00	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			
205.00	Case-mix adjusted target amount (line 203 times line 204)			
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			
209.00	Adjustment to Medicare IPPS payments (see instructions)			
210.00	Reserved for future use			
211.00	Total adjustment to Medicare IPPS payments (see instructions)			
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			
213.00	Low-volume adjustment (see instructions)			
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet DSH

Date/Time Prepared:
8/23/2021 1:52 pm

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5.24	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	16.15	0.00			16.15	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	21.39	0.00			16.15	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	80.56	0.00			80.56	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	6.86	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	3.71	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	404	0			404	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	32	0			32	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	3,166	0			3,166	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	244	0			244	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,846	0			3,846	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	23,818	0			23,818	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	23,818	0			23,818	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	16.15	0.00			16.15	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0011		Period: From 04/01/2020 To 03/31/2021		Worksheet DSH Date/Time Prepared: 8/23/2021 1:52 pm	
				Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised			
		Condition	Percentage	Condition	Percentage	Condition			
		1.00	2.00	3.00	4.00	5.00			
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE									
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	6.86		0.00	False	28.00		
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00		
30.00	Line 28 or 29 as applicable		6.86		0.00		30.00		
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		6.86		0.00		31.00		
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value			
		1.00	2.00	3.00	4.00	5.00			
DETERMINATION OF PROVIDER TYPE									
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00		
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00		
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00		
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00		
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00		

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet DSH

Date/Time Prepared:
8/23/2021 1:52 pm

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.25		29.00
30.00	Line 28 or 29 as applicable	3.25		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/23/2021 1:52 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,675	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		14,603,174	2.00
3.00	OPPS payments		10,202,764	3.00
4.00	Outlier payment (see instructions)		54,324	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		11,740,952	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		87.36	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		16,675	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		81,801	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)		81,801	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)		81,801	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		65,126	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)		16,675	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)		10,257,088	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,922,298	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)		8,351,465	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)		8,351,465	30.00
31.00	Primary payer payments		76	31.00
32.00	Subtotal (line 30 minus line 31)		8,351,389	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)		578,371	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		375,941	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		304,864	36.00
37.00	Subtotal (see instructions)		8,727,330	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)		8,727,330	40.00
40.01	Sequestration adjustment (see instructions)		13,964	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		8,787,297	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)		-73,931	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: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part B
Date/Time Prepared:
8/23/2021 1:52 pm

Title XVIII

Hospital

PPS

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part I
Date/Time Prepared:
8/23/2021 1:52 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		33,141,118		8,856,235	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		12/09/2020	1,738,938		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0	12/09/2020	68,938	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)		1,738,938		-68,938	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)		34,880,056		8,787,297	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		7,503,957		73,931	6.02
7.00	Total Medicare program liability (see instructions)		27,376,099		8,713,366	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: 14-0011 Component CCN: 14-T011	Period: From 04/01/2020 To 03/31/2021	Worksheet E-1 Part I Date/Time Prepared: 8/23/2021 1:52 pm	
		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		7,114,267		0 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	12/09/2020	31,279		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)		-31,279		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,082,988		0 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		65,037		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		7,148,025		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet E-1 Part II Date/Time Prepared: 8/23/2021 1:52 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0011 Component CCN: 14-T011	Period: From 04/01/2020 To 03/31/2021	Worksheet E-3 Part III Date/Time Prepared: 8/23/2021 1:52 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)		5,483,841	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0371	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		293,934	3.00
4.00	Outlier Payments		1,460,616	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)		21.424658	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)		7,238,391	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)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		7,238,391	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		7,238,391	19.00
20.00	Deductibles		59,364	20.00
21.00	Subtotal (line 19 minus line 20)		7,179,027	21.00
22.00	Coinurance		45,520	22.00
23.00	Subtotal (line 21 minus line 22)		7,133,507	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		39,958	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		25,973	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,893	26.00
27.00	Subtotal (sum of lines 23 and 25)		7,159,480	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)		0	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)		7,159,480	32.00
32.01	Sequestration adjustment (see instructions)		11,455	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		7,082,988	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)		65,037	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		1,460,616	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

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

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet G

Date/Time Prepared:
8/23/2021 1:52 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	5,315,896	0	11,243	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	23,337	0	0	0	3.00
4.00 Accounts receivable	108,659,079	0	0	0	4.00
5.00 Other receivable	215,398	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-87,620,570	0	0	0	6.00
7.00 Inventory	3,169,408	0	0	0	7.00
8.00 Prepaid expenses	304,829	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	30,067,377	0	11,243	0	11.00
FIXED ASSETS					
12.00 Land	5,247,668	0	0	0	12.00
13.00 Land improvements	5,926,671	0	0	0	13.00
14.00 Accumulated depreciation	-4,165,950	0	0	0	14.00
15.00 Buildings	99,498,745	0	0	0	15.00
16.00 Accumulated depreciation	-59,113,114	0	0	0	16.00
17.00 Leasehold improvements	35,549	0	0	0	17.00
18.00 Accumulated depreciation	-17,606	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	277,894	0	0	0	21.00
22.00 Accumulated depreciation	-189,446	0	0	0	22.00
23.00 Major movable equipment	39,934,957	0	0	0	23.00
24.00 Accumulated depreciation	-25,403,247	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)	62,032,121	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	999	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	1,306,611	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,307,610	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	93,407,108	0	11,243	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,991,535	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	6,472,326	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,282,555	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	37,081,967	0	0	0	43.00
44.00 Other current liabilities	1,473,633	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	51,302,016	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	41,255,348	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	723,201	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	41,978,549	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	93,280,565	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	126,543	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	11,243	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	126,543	0	11,243	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	93,407,108	0	11,243	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-1

Date/Time Prepared:
8/23/2021 1:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		33,038,437		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-32,911,807				2.00
3.00	Total (sum of line 1 and line 2)		126,630		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	RESTRICTED FUNDS	0		0		15,122	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		126,630		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	ROUNDING	87		0		0	14.00
15.00	RESTRICTED TRANSACTIONS	0		0		16,644	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)		87		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		126,543		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	12,765		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)	12,765		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00	RESTRICTED FUNDS		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)	15,122		0			10.00
11.00	Subtotal (line 3 plus line 10)	27,887		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00	ROUNDING		0				14.00
15.00	RESTRICTED TRANSACTIONS		0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	16,644		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	11,243		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
8/23/2021 1:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,841,164		25,841,164	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	15,247,704		15,247,704	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)	41,088,868		41,088,868	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,914,532		3,914,532	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,914,532		3,914,532	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,003,400		45,003,400	17.00
18.00	Ancillary services	216,070,581	418,246,622	634,317,203	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	261,073,981	418,246,622	679,320,603	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		137,544,583		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)		137,544,583		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0011

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-3

Date/Time Prepared:
8/23/2021 1:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	679,320,603	1.00
2.00	Less contractual allowances and discounts on patients' accounts	505,114,710	2.00
3.00	Net patient revenues (line 1 minus line 2)	174,205,893	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	137,544,583	4.00
5.00	Net income from service to patients (line 3 minus line 4)	36,661,310	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	30,359	6.00
7.00	Income from investments	2,156,738	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	6,815	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	564,036	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	463	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	47,393	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	586,110	22.00
23.00	Governmental appropriations	4,329	23.00
24.00	MISC., DEPARTMENTAL	14,885	24.00
24.50	COVID-19 PHE Funding	13,289,906	24.50
25.00	Total other income (sum of lines 6-24)	16,701,034	25.00
26.00	Total (line 5 plus line 25)	53,362,344	26.00
27.00	CORP ALLOC, CONTR, LOSS ON EQUIP	86,274,151	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	86,274,151	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-32,911,807	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0011	Period: From 04/01/2020 To 03/31/2021	Worksheet L Parts I-III Date/Time Prepared: 8/23/2021 1:52 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,833,362	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		41,842	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)		65.25	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,875,204	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