

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: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/24/2022 7:51 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/24/2022	Time: 7:51 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PROCTOR HOSPITAL (14-0013) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

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	-33,065	-77,934	0	0	1.00
2.00	Subprovider - IPF	0	6,092	4		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-26,974	-77,930	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: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 7:51 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 5409 N. KNOXVILLE			PO Box:				1.00	
2.00	City: PEORIA			State: IL		Zip Code: 61614		County: PEORIA	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P
4.00	Subprovider - IPF		PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF		PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P
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		PROCTOR HOSPITAL	142337	37900		05/09/2019		
18.01	Renal Dialysis		PROCTOR HOSPITAL	142338	37900		05/26/2020		
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/24/2022 7:51 am

	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.	77	0	0	0	735	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "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.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 7:51 am			
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00		
		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)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
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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.				Y		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)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 7:51 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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)	N		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.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 7:51 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,578,893	0	3,938 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/24/2022 7:51 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: PEORIA HOME OFFICE		Contractor's Name: NGS		Contractor's Number: 00131				141.00
142.00	Street: 221 NE GLEN OAK		PO Box:						142.00
143.00	City: PEORIA		State: IL		Zip Code: 61636				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		N	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N			
									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: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/24/2022 7:51 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? 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 programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/14/2022	Y 04/14/2022
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/24/2022 7:51 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEITH	LYONS		41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-712-1132	JONATHAN.LYONS@UNITYPOINT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	93	33,945	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)		93	33,945	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		109	39,785	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	30	10,590		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		153				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,524	748	9,555			1.00
2.00	HMO and other (see instructions)	2,712	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,524	748	9,555			7.00
8.00	INTENSIVE CARE UNIT	583	64	1,096			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		0	0			13.00
14.00	Total (see instructions)	5,107	812	10,651	0.00	424.50	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,350	0	4,035	0.00	28.50	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,842	0	5,600	0.00	34.20	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	487.20	27.00
28.00	Observation Bed Days		340	3,022			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			123			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: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,117	202	2,400	1.00
2.00 HMO and other (see instructions)			523	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,117	202	2,400	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	143	0	275	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/24/2022 7:51 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	27,409,152	0	27,409,152	910,631.00	30.10
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,839,351	-919,173	920,178	34,948.00	26.33
10.00	Excluded area salaries (see instructions)		2,251,862	213,629	2,465,491	109,529.00	22.51
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,865,574	0	2,865,574	54,675.00	52.41
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		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,730,037	0	7,730,037	210,418.00	36.74
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)		6,318,260	0	6,318,260		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,215,345	0	1,215,345		
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		18,473	0	18,473		
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)		1,855,046	0	1,855,046		
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: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/24/2022 7:51 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	490,046	0	490,046	16,281.00	30.10	26.00
27.00	Administrative & General	5.00	387,512	0	387,512	20,943.00	18.50	27.00
28.00	Administrative & General under contract (see inst.)		355,579	0	355,579	978.00	363.58	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,124,202	0	1,124,202	43,431.00	25.88	30.00
31.00	Laundry & Linen Service	8.00	15,448	0	15,448	1,090.00	14.17	31.00
32.00	Housekeeping	9.00	1,088,773	0	1,088,773	62,060.00	17.54	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	942,524	-665,479	277,045	14,697.00	18.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	451,850	451,850	23,971.00	18.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	154,770	0	154,770	4,902.00	31.57	38.00
39.00	Central Services and Supply	14.00	515,449	0	515,449	26,186.00	19.68	39.00
40.00	Pharmacy	15.00	1,016,273	0	1,016,273	27,271.00	37.27	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/24/2022 7:51 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	27,764,731	0	27,764,731	911,609.00	30.46	1.00
2.00	Excluded area salaries (see instructions)	4,091,213	-705,544	3,385,669	144,477.00	23.43	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,673,518	705,544	24,379,062	767,132.00	31.78	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,595,611	0	10,595,611	265,093.00	39.97	4.00
5.00	Subtotal wage-related costs (see inst.)	8,173,306	0	8,173,306	0.00	33.53	5.00
6.00	Total (sum of lines 3 thru 5)	42,442,435	705,544	43,147,979	1,032,225.00	41.80	6.00
7.00	Total overhead cost (see instructions)	6,090,576	-213,629	5,876,947	241,810.00	24.30	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	847,937	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)	1,538,646	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)	3,275,457	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	103,830	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,814	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)	236,190	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	-490,668	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,976,314	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	25,109	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	28,450	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,552,079	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: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/24/2022 7:51 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/24/2022 7:51 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.162378	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			4,936,489	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			61,680,628	6.00
7.00	Medicaid cost (line 1 times line 6)			10,015,577	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)			5,079,088	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			5,079,088	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)	2,320,768	1,535,656	3,856,424	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	376,842	1,535,656	1,912,498	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	376,842	1,535,656	1,912,498	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,761,507	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			76,221	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			117,262	27.01
28.00	Non-Medicare bad debt expense (see instructions)			4,644,245	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			795,164	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,707,662	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			7,786,750	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,332,544	1,332,544	71,417	1,403,961	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	490,046	1,158,409	1,648,455	-11,190	1,637,265	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	387,512	6,601,696	6,989,208	-72,711	6,916,497	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,908,146	1,908,146	-11	1,908,135	6.00
7.00	00700	OPERATION OF PLANT	1,124,202	2,682,344	3,806,546	-201	3,806,345	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,448	11,009	26,457	-2	26,455	8.00
9.00	00900	HOUSEKEEPING	1,088,773	719,299	1,808,072	-28,431	1,779,641	9.00
10.00	01000	DIETARY	942,524	805,192	1,747,716	-1,236,960	510,756	10.00
11.00	01100	CAFETERIA	0	0	0	837,862	837,862	11.00
13.00	01300	NURSING ADMINISTRATION	154,770	32,391	187,161	0	187,161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	515,449	744,348	1,259,797	-259,365	1,000,432	14.00
15.00	01500	PHARMACY	1,016,273	3,008,372	4,024,645	-2,724,307	1,300,338	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,096,869	3,655,235	8,752,104	-3,125,072	5,627,032	30.00
31.00	03100	INTENSIVE CARE UNIT	774,635	556,586	1,331,221	-129,056	1,202,165	31.00
40.00	04000	SUBPROVIDER - IPF	1,557,989	763,124	2,321,113	-23,198	2,297,915	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,839,351	1,609,613	3,448,964	-1,702,362	1,746,602	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,803,810	29,709,453	32,513,263	-17,101,261	15,412,002	50.00
51.00	05100	RECOVERY ROOM	1,781,239	642,859	2,424,098	-16,746	2,407,352	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,164	542,639	584,803	-389,478	195,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,677,088	925,245	2,602,333	-283,112	2,319,221	54.00
57.00	05700	CT SCAN	420,754	510,775	931,529	-143,641	787,888	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	242,954	631,337	874,291	-55,843	818,448	58.00
60.00	06000	LABORATORY	1,238,362	2,452,657	3,691,019	-266,454	3,424,565	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	176,363	176,363	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,233,182	1,233,182	64.00
65.00	06500	RESPIRATORY THERAPY	587,166	255,847	843,013	-135,588	707,425	65.00
66.00	06600	PHYSICAL THERAPY	0	791,142	791,142	705,691	1,496,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	634,855	634,855	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	266,015	266,015	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,947	1,947	-988	959	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,903,806	6,903,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,426,770	12,426,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,222,854	3,222,854	73.00
74.00	07400	RENAL DIALYSIS	386,510	872,401	1,258,911	-505,813	753,098	74.00
76.00	03950	ANCILLARY	0	0	0	-34,799	-34,799	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	49,035	49,035	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	21,274	21,274	46,539	67,813	76.02
76.03	03140	CARDIOLOGY	320,996	453,023	774,019	-70,480	703,539	76.03
76.97	07697	CARDIAC REHABILITATION	426,267	120,548	546,815	-71,912	474,903	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	106,532	116,655	223,187	2,370,089	2,593,276	90.00
91.00	09100	EMERGENCY	1,677,596	2,047,923	3,725,519	-951,628	2,773,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,715,279	65,684,033	92,399,312	-396,131	92,003,181	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	304,516	304,516	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	693,873	290,560	984,433	91,615	1,076,048	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	27,409,152	65,974,593	93,383,745	0	93,383,745	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-61,040	1,342,921	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,469,170	168,095	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,323,562	19,240,059	5.00
6.00	00600	MAINTENANCE & REPAIRS	213,750	2,121,885	6.00
7.00	00700	OPERATION OF PLANT	-10,688	3,795,657	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-4,779	21,676	8.00
9.00	00900	HOUSEKEEPING	-119	1,779,522	9.00
10.00	01000	DIETARY	-4,033	506,723	10.00
11.00	01100	CAFETERIA	0	837,862	11.00
13.00	01300	NURSING ADMINISTRATION	1,250,944	1,438,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,845	1,018,277	14.00
15.00	01500	PHARMACY	-21,745	1,278,593	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,065,686	1,065,686	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	327,384	5,954,416	30.00
31.00	03100	INTENSIVE CARE UNIT	17,843	1,220,008	31.00
40.00	04000	SUBPROVIDER - IPF	-185,688	2,112,227	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	26,739	1,773,341	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-596,935	14,815,067	50.00
51.00	05100	RECOVERY ROOM	0	2,407,352	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67,497	262,822	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-35,731	2,283,490	54.00
57.00	05700	CT SCAN	-40,547	747,341	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	51,467	869,915	58.00
60.00	06000	LABORATORY	-75,267	3,349,298	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	176,363	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,233,182	64.00
65.00	06500	RESPIRATORY THERAPY	404	707,829	65.00
66.00	06600	PHYSICAL THERAPY	0	1,496,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	634,855	67.00
68.00	06800	SPEECH PATHOLOGY	0	266,015	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	959	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,903,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,426,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,222,854	73.00
74.00	07400	RENAL DIALYSIS	0	753,098	74.00
76.00	03950	ANCILLARY	0	-34,799	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	49,035	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	12,427	80,240	76.02
76.03	03140	CARDIOLOGY	11,800	715,339	76.03
76.97	07697	CARDIAC REHABILITATION	24,450	499,353	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	41,501	2,634,777	90.00
91.00	09100	EMERGENCY	-852,922	1,920,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,094,635	104,097,816	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	194.01
194.02	07952	MARKETING	0	0	194.02
194.03	07953	GUEST MEALS	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	304,516	194.04
194.05	07955	FOUNDATION	0	0	194.05
194.06	07956	DAYCARE CENTER	0	1,076,048	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	194.08
194.09	07959	ARC BROMENN	0	0	194.09
194.10	07960	ARC INGALLS	17,873	17,873	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	12,112,508	105,496,253	200.00

RECLASSIFICATIONS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet A-6
Date/Time Prepared:
5/24/2022 7:51 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	451,850	386,012		1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	164,222	140,294		2.00
3.00	DAYCARE CENTER	194.06	49,407	42,208		3.00
	0		665,479	568,514		
	D - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,417		1.00
	0		0	71,417		
	F - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,222,854		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	3,222,854		
	G - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,903,806		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
	0		0	6,903,806		
	I - IMPLANTIBLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,426,770		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

RECLASSIFICATIONS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/24/2022 7:51 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	12,426,770	
J - BLOOD RECLASS					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	176,363	1.00
	0		0	176,363	
K - COST CENTER MAPPING					
1.00	INTENSIVE CARE UNIT	31.00	2,997	435	1.00
2.00	OPERATING ROOM	50.00	84,264	33,333	2.00
3.00	RECOVERY ROOM	51.00	83,965	62,014	3.00
4.00	ANESTHESIOLOGY	53.00	2,851	1,054	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	2,342	1,347	5.00
6.00	INTRAVENOUS THERAPY	64.00	696,910	536,272	6.00
7.00	RESPIRATORY THERAPY	65.00	52,005	13,978	7.00
8.00	PHYSICAL THERAPY	66.00	531,572	398,666	8.00
9.00	OCCUPATIONAL THERAPY	67.00	309,011	325,844	9.00
10.00	SPEECH PATHOLOGY	68.00	78,590	187,425	10.00
11.00	PULMONARY FUNCTION TESTING	76.01	38,163	10,872	11.00
12.00	GASTRO INTESTINAL SERVICES	76.02	28,960	19,869	12.00
13.00	CARDIOLOGY	76.03	142,135	114,908	13.00
14.00	CLINIC	90.00	1,133,083	1,238,237	14.00
	0		3,186,848	2,944,254	
500.00	Grand Total: Increases		3,852,327	26,313,978	500.00

RECLASSIFICATIONS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/24/2022 7:51 am

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	665,479	568,514	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		665,479	568,514			
	D - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	71,417	12		1.00
	0		0	71,417			
	F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,988	0		1.00
2.00	DIETARY	10.00	0	2,245	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,200	0		3.00
4.00	PHARMACY	15.00	0	2,656,294	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	51,327	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	11,824	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	719	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	3,537	0		8.00
9.00	OPERATING ROOM	50.00	0	68,494	0		9.00
10.00	RECOVERY ROOM	51.00	0	54,440	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	46,371	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,419	0		12.00
13.00	CT SCAN	57.00	0	15,195	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	40,351	0		14.00
15.00	LABORATORY	60.00	0	796	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	2,670	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	90	0		17.00
18.00	RENAL DIALYSIS	74.00	0	136,313	0		18.00
19.00	ANCILLARY	76.00	0	34,799	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	177	0		20.00
21.00	EMERGENCY	91.00	0	78,605	0		21.00
	0		0	3,222,854			
	G - MED SUPPLIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	202	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,294	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	11	0		3.00
4.00	OPERATION OF PLANT	7.00	0	201	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	2	0		5.00
6.00	HOUSEKEEPING	9.00	0	28,431	0		6.00
7.00	DIETARY	10.00	0	722	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	163,143	0		8.00
9.00	PHARMACY	15.00	0	65,007	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	365,232	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	82,814	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	22,078	0		12.00
13.00	SKILLED NURSING FACILITY	44.00	0	89,653	0		13.00
14.00	OPERATING ROOM	50.00	0	4,574,179	0		14.00
15.00	RECOVERY ROOM	51.00	0	83,492	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	343,260	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	129,730	0		17.00
18.00	CT SCAN	57.00	0	124,946	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	13,076	0		19.00
20.00	LABORATORY	60.00	0	89,295	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	85,298	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	1,968	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	898	0		23.00
24.00	RENAL DIALYSIS	74.00	0	365,608	0		24.00
25.00	GASTRO INTESTINAL SERVICES	76.02	0	2,290	0		25.00
26.00	CARDIOLOGY	76.03	0	82,633	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	5,752	0		27.00
28.00	CLINIC	90.00	0	1,231	0		28.00
29.00	EMERGENCY	91.00	0	181,360	0		29.00
	0		0	6,903,806			
	I - IMPLANTIBLE RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	94,022	0		1.00
2.00	PHARMACY	15.00	0	3,006	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	10,464	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	5,589	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	401	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	643	0		6.00
7.00	OPERATING ROOM	50.00	0	11,999,083	0		7.00
8.00	RECOVERY ROOM	51.00	0	24,793	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	3,752	0		9.00

RECLASSIFICATIONS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/24/2022 7:51 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,223	0	10.00
11.00	CT SCAN	57.00	0	3,500	0	11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,416	0	12.00
13.00	RENAL DIALYSIS	74.00	0	71	0	13.00
14.00	CARDIOLOGY	76.03	0	200,163	0	14.00
15.00	EMERGENCY	91.00	0	36,644	0	15.00
	0		0	12,426,770		
J - BLOOD RECLASS						
1.00	LABORATORY	60.00	0	176,363	0	1.00
	0		0	176,363		
K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	1,609,275	1,088,774	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	20,437	11,824	0	2.00
3.00	SKILLED NURSING FACILITY	44.00	919,173	689,356	0	3.00
4.00	OPERATING ROOM	50.00	72,898	504,204	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	80,228	29,201	0	5.00
6.00	RESPIRATORY THERAPY	65.00	88,416	25,187	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	222,579	0	7.00
8.00	RENAL DIALYSIS	74.00	3,336	485	0	8.00
9.00	CARDIOLOGY	76.03	28,393	16,334	0	9.00
10.00	CARDIAC REHABILITATION	76.97	52,005	13,978	0	10.00
11.00	EMERGENCY	91.00	312,687	342,332	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
	0		3,186,848	2,944,254		
500.00	Grand Total: Decreases		3,852,327	26,313,978		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/24/2022 7:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,081,907	0	0	0	0	1.00	
2.00	Land Improvements	6,699,500	164,528	0	164,528	0	2.00	
3.00	Buildings and Fixtures	74,390,610	3,334,619	0	3,334,619	2,521,104	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	20,721,686	46,510	0	46,510	0	5.00	
6.00	Movable Equipment	65,166,944	1,320,801	0	1,320,801	109,910	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	173,060,647	4,866,458	0	4,866,458	2,631,014	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	173,060,647	4,866,458	0	4,866,458	2,631,014	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,081,907	0				1.00	
2.00	Land Improvements	6,864,028	0				2.00	
3.00	Buildings and Fixtures	75,204,125	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	20,768,196	0				5.00	
6.00	Movable Equipment	66,377,835	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	175,296,091	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	175,296,091	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,332,544	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,332,544	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	1,332,544				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,332,544				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	20,768,196	0	20,768,196	0.118111	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	155,067,895	0	155,067,895	0.881889	0	2.00
3.00	Total (sum of lines 1-2)	175,836,091	0	175,836,091	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,332,544	54,499	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,332,544	54,499	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-115,539	71,417	0	0	1,342,921	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-115,539	71,417	0	0	1,342,921	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	-1,529,745			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	15,406,736			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
19.04	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.04
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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISC REVENUE	B	-75,990	OPERATION OF PLANT	7.00	0	33.01
33.02	MISC REVENUE	B	-4,779	LAUNDRY & LINEN SERVICE	8.00	0	33.02
33.03	MISC REVENUE	B	-119	HOUSEKEEPING	9.00	0	33.03
33.04	MISC REVENUE	B	-16,995	DIETARY	10.00	0	33.04
33.05	MISC REVENUE	B	-10,030	PHARMACY	15.00	0	33.05
33.06	MISC REVENUE	B	-8,830	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	MISC REVENUE	B	-1,053	INTENSIVE CARE UNIT	31.00	0	33.07
33.08	MISC REVENUE	B	-1,099	SKILLED NURSING FACILITY	44.00	0	33.08
33.09	MISC REVENUE	B	-417,033	OPERATING ROOM	50.00	0	33.09
33.10	MISC REVENUE	B	-4,812	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	MISC REVENUE	B	-13,871	CARDIAC REHABILITATION	76.97	0	33.11
33.12	MISC REVENUE	B	-25,123	EMERGENCY	91.00	0	33.12
33.13	DEPR TO AHA	A	54,499	CAP REL COSTS-BLDG & FIXT	1.00	10	33.13
33.14	DEPR TO AHA	A	547	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	DEPR TO AHA	A	213,750	MAINTENANCE & REPAIRS	6.00	0	33.15
33.16	DEPR TO AHA	A	17,423	OPERATION OF PLANT	7.00	0	33.16
33.17	DEPR TO AHA	A	12,962	DIETARY	10.00	0	33.17
33.18	DEPR TO AHA	A	17,845	CENTRAL SERVICES & SUPPLY	14.00	0	33.18
33.19	DEPR TO AHA	A	-11,715	PHARMACY	15.00	0	33.19
33.20	DEPR TO AHA	A	75,443	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	DEPR TO AHA	A	18,896	INTENSIVE CARE UNIT	31.00	0	33.21
33.22	DEPR TO AHA	A	28,291	SUBPROVIDER - IPF	40.00	0	33.22
33.23	DEPR TO AHA	A	27,838	SKILLED NURSING FACILITY	44.00	0	33.23
33.24	DEPR TO AHA	A	93,848	OPERATING ROOM	50.00	0	33.24
33.25	DEPR TO AHA	A	67,497	ANESTHESIOLOGY	53.00	0	33.25
33.26	DEPR TO AHA	A	35,081	RADIOLOGY-DIAGNOSTIC	54.00	0	33.26
33.27	DEPR TO AHA	A	-40,547	CT SCAN	57.00	0	33.27
33.28	DEPR TO AHA	A	51,467	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.28
33.29	DEPR TO AHA	A	-1,316	LABORATORY	60.00	0	33.29
33.30	DEPR TO AHA	A	404	RESPIRATORY THERAPY	65.00	0	33.30
33.31	DEPR TO AHA	A	12,427	GASTRO INTESTINAL SERVICES	76.02	0	33.31
33.32	DEPR TO AHA	A	11,800	CARDIOLOGY	76.03	0	33.32
33.33	DEPR TO AHA	A	58,871	CARDIAC REHABILITATION	76.97	0	33.33
33.34	DEPR TO AHA	A	41,501	CLINIC	90.00	0	33.34
33.35	DEPR TO AHA	A	9,816	EMERGENCY	91.00	0	33.35
33.36	DEPR TO AHA	A	17,873	ARC INGALLS	194.10	0	33.36
33.37	DEPR TO AHA	A	0		0.00	0	33.37
33.39	DEPR TO AHA	A	0		0.00	0	33.39
33.40	DEPR TO AHA	A	0		0.00	0	33.40
33.41	ADVERTISING	A	-20,018	ADULTS & PEDIATRICS	30.00	0	33.41
33.42	ADVERTISING	A	0		0.00	0	33.42
33.43	POB SECURITY COST	A	-25,304	OPERATION OF PLANT	7.00	0	33.43
33.44	POB SECURITY COST	A	-4,431	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	SELF FUNDED INSURANCE	A	-1,849,372	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	NON-ALLOWABLE INTEREST	A	-100,125	CAP REL COSTS-BLDG & FIXT	1.00	11	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		12,112,508				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.

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	

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: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/24/2022 7:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	384,633	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	1,065,686	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	1,250,944	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	73,183	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	12,323,015	0	4.00
4.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE ALLOCATION	324,689	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	446,586	462,000	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,868,736	462,000	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	Name	Percentage of Ownership
	4.00	5.00			

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

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

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

6.00	B	100.00	UNITY POINT	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/24/2022 7:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	384,633	0		1.00
2.00	1,065,686	0		2.00
3.00	1,250,944	0		3.00
3.01	73,183	0		3.01
4.00	12,323,015	0		4.00
4.01	324,689	0		4.01
4.02	-15,414	11		4.02
5.00	15,406,736			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	HEALTH SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-2

Date/Time Prepared:
5/24/2022 7:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	43,900	43,900	0	181,300	0	1.00
2.00	40.00	SUBPROVIDER - IPF	213,979	213,979	0	181,300	0	2.00
3.00	50.00	OPERATING ROOM	273,750	273,750	0	246,400	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	66,000	66,000	0	271,900	0	4.00
5.00	60.00	LABORATORY	73,951	73,951	0	260,300	0	5.00
6.00	76.97	CARDIAC REHABILITATION	20,550	20,550	0	211,500	0	6.00
7.00	91.00	EMERGENCY	837,615	837,615	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,529,745	1,529,745	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	43,900		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	213,979		2.00
3.00	50.00	OPERATING ROOM	0	0	0	273,750		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	66,000		4.00
5.00	60.00	LABORATORY	0	0	0	73,951		5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	20,550		6.00
7.00	91.00	EMERGENCY	0	0	0	837,615		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,529,745		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,342,921	1,342,921			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	168,095	11,244	0	179,339	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,240,059	243,713	0	2,582	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,121,885	4,428	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,795,657	267,772	0	7,489	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,676	7,439	0	103	8.00
9.00	00900	HOUSEKEEPING	1,779,522	51,422	0	7,253	9.00
10.00	01000	DIETARY	506,723	55,837	0	1,846	10.00
11.00	01100	CAFETERIA	837,862	0	0	3,010	11.00
13.00	01300	NURSING ADMINISTRATION	1,438,105	0	0	1,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,018,277	33,733	0	3,434	14.00
15.00	01500	PHARMACY	1,278,593	12,527	0	6,770	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,065,686	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,954,416	89,428	0	23,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,220,008	29,518	0	5,044	31.00
40.00	04000	SUBPROVIDER - IPF	2,112,227	27,720	0	10,379	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,773,341	104,965	0	6,130	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,815,067	49,824	0	18,755	50.00
51.00	05100	RECOVERY ROOM	2,407,352	35,704	0	12,426	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	262,822	0	0	300	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,283,490	27,818	0	10,654	54.00
57.00	05700	CT SCAN	747,341	5,002	0	2,803	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	869,915	61,560	0	1,619	58.00
60.00	06000	LABORATORY	3,349,298	38,416	0	8,250	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	176,363	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,233,182	0	0	4,643	64.00
65.00	06500	RESPIRATORY THERAPY	707,829	12,162	0	3,669	65.00
66.00	06600	PHYSICAL THERAPY	1,496,833	24,205	0	3,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	634,855	0	0	2,059	67.00
68.00	06800	SPEECH PATHOLOGY	266,015	0	0	524	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	959	0	0	959	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,903,806	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,426,770	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,222,854	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	753,098	32,857	0	2,553	74.00
76.00	03950	ANCILLARY	-34,799	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	49,035	0	0	254	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	80,240	0	0	193	76.02
76.03	03140	CARDIOLOGY	715,339	3,920	0	2,896	76.03
76.97	07697	CARDIAC REHABILITATION	499,353	20,277	0	2,493	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,634,777	1,745	0	8,258	90.00
91.00	09100	EMERGENCY	1,920,969	48,984	0	9,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,097,816	1,302,220	0	173,293	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	304,516	0	0	1,094	194.04
194.05	07955	FOUNDATION	0	0	0	329	194.05
194.06	07956	DAYCARE CENTER	1,076,048	40,701	0	4,623	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	194.09
194.10	07960	ARC INGALLS	17,873	0	0	0	194.10
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	105,496,253	1,342,921	0	179,339	105,496,253	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,486,354					5.00
6.00	00600	MAINTENANCE & REPAIRS	481,542	2,607,855				6.00
7.00	00700	OPERATION OF PLANT	921,933	644,470	5,637,321			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,617	17,904	51,407	105,146		8.00
9.00	00900	HOUSEKEEPING	416,293	123,762	355,347	0	2,733,599	9.00
10.00	01000	DIETARY	127,820	134,390	385,863	0	201,660	10.00
11.00	01100	CAFETERIA	190,431	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	325,918	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	239,024	81,190	233,114	0	121,830	14.00
15.00	01500	PHARMACY	293,931	30,149	86,565	0	45,241	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,344	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,374,000	215,234	617,987	49,525	322,972	30.00
31.00	03100	INTENSIVE CARE UNIT	284,120	71,045	203,986	5,681	106,607	31.00
40.00	04000	SUBPROVIDER - IPF	486,980	66,717	191,559	20,914	100,112	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	426,764	252,630	725,358	29,026	379,089	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,370,650	119,916	344,307	0	179,942	50.00
51.00	05100	RECOVERY ROOM	556,088	85,932	246,730	0	128,946	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	59,589	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,850	66,953	192,238	0	100,467	54.00
57.00	05700	CT SCAN	171,016	12,038	34,564	0	18,064	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	211,316	148,163	425,409	0	222,327	58.00
60.00	06000	LABORATORY	769,077	92,459	265,470	0	138,740	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	39,941	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	280,328	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	163,886	29,272	84,046	0	43,924	65.00
66.00	06600	PHYSICAL THERAPY	345,268	58,258	167,271	0	87,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,241	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	60,363	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	217	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,563,491	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,814,266	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	729,873	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	178,572	79,080	227,057	0	118,664	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	11,162	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	18,216	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	163,545	9,435	27,091	0	14,158	76.03
76.97	07697	CARDIAC REHABILITATION	118,244	48,803	140,123	0	73,231	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	598,958	4,200	12,059	0	6,302	90.00
91.00	09100	EMERGENCY	448,191	117,895	338,504	0	176,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,159,065	2,509,895	5,356,055	105,146	2,586,604	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	69,211	0	0	0	0	194.04
194.05	07955	FOUNDATION	75	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	253,955	97,960	281,266	0	146,995	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	4,048	0	0	0	0	194.10
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)	19,486,354	2,607,855	5,637,321	105,146	2,733,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,414,139					10.00
11.00	01100	CAFETERIA	0	1,031,303				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,767	1,772,821			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,867	0	1,756,469		14.00
15.00	01500	PHARMACY	0	51,000	0	0	1,804,776	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	666,080	175,006	410,110	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	76,402	37,998	89,039	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	281,280	78,185	183,205	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	390,377	46,177	108,205	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	141,274	331,039	0	0	50.00
51.00	05100	RECOVERY ROOM	0	93,602	219,331	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,259	5,293	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,253	188,052	0	0	54.00
57.00	05700	CT SCAN	0	21,115	49,477	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,192	28,569	0	0	58.00
60.00	06000	LABORATORY	0	62,145	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	34,973	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	27,639	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,676	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,507	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,944	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	625,803	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,130,666	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,804,776	73.00
74.00	07400	RENAL DIALYSIS	0	19,229	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
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	68,495	160,501	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,414,139	1,031,303	1,772,821	1,756,469	1,804,776	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	1,414,139	1,031,303	1,772,821	1,756,469	1,804,776	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,307,030					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	65,932	0	9,963,929	0	9,963,929	30.00
31.00	03100	INTENSIVE CARE UNIT	11,961	0	2,141,409	0	2,141,409	31.00
40.00	04000	SUBPROVIDER - IPF	20,923	0	3,580,201	0	3,580,201	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	11,458	0	4,253,520	0	4,253,520	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	281,465	0	19,652,239	0	19,652,239	50.00
51.00	05100	RECOVERY ROOM	64,693	0	3,850,804	0	3,850,804	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	73,509	0	403,772	0	403,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,548	0	3,523,323	0	3,523,323	54.00
57.00	05700	CT SCAN	95,027	0	1,156,447	0	1,156,447	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	36,900	0	2,017,970	0	2,017,970	58.00
60.00	06000	LABORATORY	82,062	0	4,805,917	0	4,805,917	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,860	0	219,164	0	219,164	63.00
64.00	06400	INTRAVENOUS THERAPY	25,965	0	1,579,091	0	1,579,091	64.00
65.00	06500	RESPIRATORY THERAPY	15,330	0	1,087,757	0	1,087,757	65.00
66.00	06600	PHYSICAL THERAPY	12,984	0	2,222,455	0	2,222,455	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,181	0	801,843	0	801,843	67.00
68.00	06800	SPEECH PATHOLOGY	2,133	0	332,979	0	332,979	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	249	0	1,425	0	1,425	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,033	0	9,147,133	0	9,147,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	163,005	0	16,534,707	0	16,534,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,298	0	5,814,801	0	5,814,801	73.00
74.00	07400	RENAL DIALYSIS	22,970	0	1,434,080	0	1,434,080	74.00
76.00	03950	ANCILLARY	0	0	-34,799	0	-34,799	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,913	0	62,364	0	62,364	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	2,622	0	101,271	0	101,271	76.02
76.03	03140	CARDIOLOGY	29,972	0	966,356	0	966,356	76.03
76.97	07697	CARDIAC REHABILITATION	2,818	0	905,342	0	905,342	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	33,467	0	3,299,766	0	3,299,766	90.00
91.00	09100	EMERGENCY	82,752	0	3,372,293	0	3,372,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,307,030	0	103,197,559	0	103,197,559	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	374,821	0	374,821	194.04
194.05	07955	FOUNDATION	0	0	404	0	404	194.05
194.06	07956	DAYCARE CENTER	0	0	1,901,548	0	1,901,548	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	21,921	0	21,921	194.10
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)	1,307,030	0	105,496,253	0	105,496,253	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 7:51 am

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	792,974	11,244	0	804,218	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	243,713	0	243,713	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,171	4,428	0	10,599	6.00
7.00	00700	OPERATION OF PLANT	19,699	267,772	0	287,471	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713,950	7,439	0	721,389	8.00
9.00	00900	HOUSEKEEPING	210,333	51,422	0	261,755	9.00
10.00	01000	DIETARY	0	55,837	0	55,837	10.00
11.00	01100	CAFETERIA	14,638	0	0	14,638	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,733	0	33,733	14.00
15.00	01500	PHARMACY	0	12,527	0	12,527	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,566	0	0	166,566	16.00
17.00	01700	SOCIAL SERVICE	69,317	0	0	69,317	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	109,256	89,428	0	198,684	30.00
31.00	03100	INTENSIVE CARE UNIT	65,366	29,518	0	94,884	31.00
40.00	04000	SUBPROVIDER - IPF	88,774	27,720	0	116,494	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	77,622	104,965	0	182,587	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	498,865	49,824	0	548,689	50.00
51.00	05100	RECOVERY ROOM	22,817	35,704	0	58,521	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	192,237	0	0	192,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,399	27,818	0	260,217	54.00
57.00	05700	CT SCAN	215,393	5,002	0	220,395	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	563,195	61,560	0	624,755	58.00
60.00	06000	LABORATORY	112,829	38,416	0	151,245	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	35,313	0	0	35,313	64.00
65.00	06500	RESPIRATORY THERAPY	25,256	12,162	0	37,418	65.00
66.00	06600	PHYSICAL THERAPY	49,293	24,205	0	73,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,238	0	0	27,238	67.00
68.00	06800	SPEECH PATHOLOGY	7,239	0	0	7,239	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71,023	0	0	71,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	191,958	32,857	0	224,815	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,176	0	0	2,176	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	30,029	0	0	30,029	76.02
76.03	03140	CARDIOLOGY	62,989	3,920	0	66,909	76.03
76.97	07697	CARDIAC REHABILITATION	58,186	20,277	0	78,463	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	225,210	1,745	0	226,955	90.00
91.00	09100	EMERGENCY	119,110	48,984	0	168,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,077,421	1,302,220	0	6,379,641	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	18,448	40,701	0	59,149	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	5,095,869	1,342,921	0	6,438,790	804,218	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	255,290					5.00
6.00	00600	MAINTENANCE & REPAIRS	6,309	16,908				6.00
7.00	00700	OPERATION OF PLANT	12,078	4,181	337,316			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87	116	3,076	725,130		8.00
9.00	00900	HOUSEKEEPING	5,454	802	21,263	0	321,801	9.00
10.00	01000	DIETARY	1,675	871	23,089	0	23,740	10.00
11.00	01100	CAFETERIA	2,495	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,270	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,132	526	13,949	0	14,342	14.00
15.00	01500	PHARMACY	3,851	195	5,180	0	5,326	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,162	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,001	1,395	36,978	341,547	38,020	30.00
31.00	03100	INTENSIVE CARE UNIT	3,722	461	12,206	39,177	12,550	31.00
40.00	04000	SUBPROVIDER - IPF	6,380	433	11,462	144,232	11,785	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,591	1,638	43,401	200,174	44,625	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,153	777	20,602	0	21,183	50.00
51.00	05100	RECOVERY ROOM	7,285	557	14,763	0	15,180	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	781	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,889	434	11,503	0	11,827	54.00
57.00	05700	CT SCAN	2,241	78	2,068	0	2,126	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,768	961	25,455	0	26,173	58.00
60.00	06000	LABORATORY	10,076	599	15,885	0	16,333	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	523	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	3,673	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,147	190	5,029	0	5,171	65.00
66.00	06600	PHYSICAL THERAPY	4,523	378	10,009	0	10,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,890	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	791	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,484	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,870	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,562	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,340	513	13,586	0	13,969	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	146	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	239	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	2,143	61	1,621	0	1,667	76.03
76.97	07697	CARDIAC REHABILITATION	1,549	316	8,384	0	8,621	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,847	27	722	0	742	90.00
91.00	09100	EMERGENCY	5,872	764	20,255	0	20,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	251,002	16,273	320,486	725,130	304,497	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	907	0	0	0	0	194.04
194.05	07955	FOUNDATION	1	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	3,327	635	16,830	0	17,304	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	53	0	0	0	0	194.10
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)	255,290	16,908	337,316	725,130	321,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	113,489					10.00
11.00	01100	CAFETERIA	0	30,632				11.00
13.00	01300	NURSING ADMINISTRATION	0	231	9,125			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	769	0	81,850		14.00
15.00	01500	PHARMACY	0	1,515	0	0	58,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,454	5,192	2,113	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,132	1,129	458	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	22,574	2,323	943	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	31,329	1,372	557	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,197	1,703	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,781	1,128	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	67	27	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,384	968	0	0	54.00
57.00	05700	CT SCAN	0	627	255	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	362	147	0	0	58.00
60.00	06000	LABORATORY	0	1,846	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,039	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	821	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	793	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	461	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	117	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,162	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,688	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	58,955	73.00
74.00	07400	RENAL DIALYSIS	0	571	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
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	2,035	826	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,489	30,632	9,125	81,850	58,955	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	113,489	30,632	9,125	81,850	58,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	169,728					16.00
17.00	01700	SOCIAL SERVICE	0	69,317				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,562	32,649	840,797	0	840,797	30.00
31.00	03100	INTENSIVE CARE UNIT	1,553	3,745	198,638	0	198,638	31.00
40.00	04000	SUBPROVIDER - IPF	2,717	13,788	379,676	0	379,676	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,488	19,135	559,387	0	559,387	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,546	0	761,953	0	761,953	50.00
51.00	05100	RECOVERY ROOM	8,401	0	164,339	0	164,339	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,546	0	204,003	0	204,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,175	0	348,173	0	348,173	54.00
57.00	05700	CT SCAN	12,341	0	252,701	0	252,701	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,792	0	692,671	0	692,671	58.00
60.00	06000	LABORATORY	10,657	0	243,637	0	243,637	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	371	0	894	0	894	63.00
64.00	06400	INTRAVENOUS THERAPY	3,372	0	64,217	0	64,217	64.00
65.00	06500	RESPIRATORY THERAPY	1,991	0	69,221	0	69,221	65.00
66.00	06600	PHYSICAL THERAPY	1,686	0	117,059	0	117,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	673	0	39,494	0	39,494	67.00
68.00	06800	SPEECH PATHOLOGY	277	0	10,772	0	10,772	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	32	0	35	0	35	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,017	0	127,686	0	127,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,168	0	110,726	0	110,726	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,441	0	75,958	0	75,958	73.00
74.00	07400	RENAL DIALYSIS	2,983	0	270,224	0	270,224	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	248	0	3,710	0	3,710	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	341	0	31,474	0	31,474	76.02
76.03	03140	CARDIOLOGY	3,892	0	89,281	0	89,281	76.03
76.97	07697	CARDIAC REHABILITATION	366	0	108,880	0	108,880	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,346	0	277,672	0	277,672	90.00
91.00	09100	EMERGENCY	10,746	0	270,195	0	270,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,728	69,317	6,313,473	0	6,313,473	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	5,813	0	5,813	194.04
194.05	07955	FOUNDATION	0	0	1,477	0	1,477	194.05
194.06	07956	DAYCARE CENTER	0	0	117,974	0	117,974	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	53	0	53	194.10
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)	169,728	69,317	6,438,790	0	6,438,790	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	327,833				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		327,833			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,745	2,745	26,919,108		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	59,495	59,495	387,512	-19,486,354	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,081	1,081	0	0	6.00
7.00	00700	OPERATION OF PLANT	65,368	65,368	1,124,202	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,816	1,816	15,448	0	8.00
9.00	00900	HOUSEKEEPING	12,553	12,553	1,088,773	0	9.00
10.00	01000	DIETARY	13,631	13,631	277,045	0	10.00
11.00	01100	CAFETERIA	0	0	451,850	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	154,770	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,235	8,235	515,449	0	14.00
15.00	01500	PHARMACY	3,058	3,058	1,016,273	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,831	21,831	3,487,595	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,206	7,206	757,195	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,767	6,767	1,557,989	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	25,624	25,624	920,178	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,163	12,163	2,815,176	0	50.00
51.00	05100	RECOVERY ROOM	8,716	8,716	1,865,204	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	45,015	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,791	6,791	1,599,202	0	54.00
57.00	05700	CT SCAN	1,221	1,221	420,754	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,028	15,028	242,954	0	58.00
60.00	06000	LABORATORY	9,378	9,378	1,238,362	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	696,910	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,969	2,969	550,755	0	65.00
66.00	06600	PHYSICAL THERAPY	5,909	5,909	531,572	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	309,011	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	78,590	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,021	8,021	383,175	0	74.00
76.00	03950	ANCILLARY	0	0	0	34,799	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	38,163	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	28,960	0	76.02
76.03	03140	CARDIOLOGY	957	957	434,738	0	76.03
76.97	07697	CARDIAC REHABILITATION	4,950	4,950	374,262	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	426	426	1,239,615	0	90.00
91.00	09100	EMERGENCY	11,958	11,958	1,364,909	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	317,897	317,897	26,011,606	-19,451,555	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	164,222	0	194.04
194.05	07955	FOUNDATION	0	0	49,407	0	194.05
194.06	07956	DAYCARE CENTER	9,936	9,936	693,873	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	194.10
200.00		Cross Foot Adjustments				17,873	200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,342,921	0	179,339		19,486,354	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.096357	0.000000	0.006662		0.226468	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			804,218		255,290	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.029875		0.002967	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: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	264,512					6.00
7.00	00700	OPERATION OF PLANT	65,368	199,144				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,816	1,816	20,286			8.00
9.00	00900	HOUSEKEEPING	12,553	12,553	0	184,775		9.00
10.00	01000	DIETARY	13,631	13,631	0	13,631	20,286	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,235	8,235	0	8,235	0	14.00
15.00	01500	PHARMACY	3,058	3,058	0	3,058	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,831	21,831	9,555	21,831	9,555	30.00
31.00	03100	INTENSIVE CARE UNIT	7,206	7,206	1,096	7,206	1,096	31.00
40.00	04000	SUBPROVIDER - IPF	6,767	6,767	4,035	6,767	4,035	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	25,624	25,624	5,600	25,624	5,600	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,163	12,163	0	12,163	0	50.00
51.00	05100	RECOVERY ROOM	8,716	8,716	0	8,716	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,791	6,791	0	6,791	0	54.00
57.00	05700	CT SCAN	1,221	1,221	0	1,221	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,028	15,028	0	15,028	0	58.00
60.00	06000	LABORATORY	9,378	9,378	0	9,378	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,969	2,969	0	2,969	0	65.00
66.00	06600	PHYSICAL THERAPY	5,909	5,909	0	5,909	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,021	8,021	0	8,021	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	957	957	0	957	0	76.03
76.97	07697	CARDIAC REHABILITATION	4,950	4,950	0	4,950	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	426	426	0	426	0	90.00
91.00	09100	EMERGENCY	11,958	11,958	0	11,958	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	254,576	189,208	20,286	174,839	20,286	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	9,936	9,936	0	9,936	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	2,607,855	5,637,321	105,146	2,733,599	1,414,139	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	9.859118	28.307762	5.183181	14.794204	69.710096	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16,908	337,316	725,130	321,801	113,489	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.063921	1.693830	35.745342	1.741583	5.594449	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: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			CAFETERIA (GROSS SALA RIE)	NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	20,551,038					11.00
13.00	01300	NURSING ADMINISTRATION	154,770	15,076,171				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	515,449	0	19,304,710			14.00
15.00	01500	PHARMACY	1,016,273	0	0	3,222,856		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	635,753,240	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,487,595	3,487,595	0	0	32,067,959	30.00
31.00	03100	INTENSIVE CARE UNIT	757,195	757,195	0	0	5,817,755	31.00
40.00	04000	SUBPROVIDER - IPF	1,557,989	1,557,989	0	0	10,176,478	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	920,178	920,178	0	0	5,573,135	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,815,176	2,815,176	0	0	136,936,469	50.00
51.00	05100	RECOVERY ROOM	1,865,204	1,865,204	0	0	31,465,284	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,015	45,015	0	0	35,753,403	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,599,202	1,599,202	0	0	23,126,512	54.00
57.00	05700	CT SCAN	420,754	420,754	0	0	46,219,242	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	242,954	242,954	0	0	17,947,454	58.00
60.00	06000	LABORATORY	1,238,362	0	0	0	39,913,477	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	1,391,079	63.00
64.00	06400	INTRAVENOUS THERAPY	696,910	0	0	0	12,629,096	64.00
65.00	06500	RESPIRATORY THERAPY	550,755	0	0	0	7,456,275	65.00
66.00	06600	PHYSICAL THERAPY	531,572	0	0	0	6,315,230	66.00
67.00	06700	OCCUPATIONAL THERAPY	309,011	0	0	0	2,519,882	67.00
68.00	06800	SPEECH PATHOLOGY	78,590	0	0	0	1,037,623	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	121,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,877,941	0	26,280,576	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,426,769	0	79,282,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,222,856	27,868,817	73.00
74.00	07400	RENAL DIALYSIS	383,175	0	0	0	11,172,291	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	930,674	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	1,275,336	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	14,577,949	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1,370,669	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	16,277,890	90.00
91.00	09100	EMERGENCY	1,364,909	1,364,909	0	0	40,248,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,551,038	15,076,171	19,304,710	3,222,856	635,753,240	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		CAFETERIA (GROSS SALA RIE)	NURSING ADMINISTRATION (NURSING SA LARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,031,303	1,772,821	1,756,469	1,804,776	1,307,030	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.050183	0.117591	0.090987	0.559993	0.002056	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	30,632	9,125	81,850	58,955	169,728	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001491	0.000605	0.004240	0.018293	0.000267	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: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		20,286	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		9,555	
		1,096	
		4,035	
		0	
		5,600	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	ANCILLARY	76.00
76.01	03560	PULMONARY FUNCTION TESTING	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	76.02
76.03	03140	CARDIOLOGY	76.03
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
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		20,286	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	194.00
194.01	07951	MEALS ON WHEELS	194.01
194.02	07952	MARKETING	194.02
194.03	07953	GUEST MEALS	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	194.04
194.05	07955	FOUNDATION	194.05
194.06	07956	DAYCARE CENTER	194.06
194.07	07957	UN-USED SQR FT - POB	194.07
194.08	07958	SENIOR SERVICES	194.08
194.09	07959	ARC BROMENN	194.09
194.10	07960	ARC INGALLS	194.10
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)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		SOCIAL SERVICE	
		(PATIENT DAYS)	
		17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	69,317	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.416987	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

MCRIF32 - 17.4.174.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 7:51 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,819,403		26,819,403		30.00
31.00	03100	INTENSIVE CARE UNIT	5,817,755		5,817,755		31.00
40.00	04000	SUBPROVIDER - IPF	10,176,478		10,176,478		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,573,135		5,573,135		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,806,807	126,129,662	136,936,469	0.143514	0.000000
51.00	05100	RECOVERY ROOM	2,592,325	28,872,959	31,465,284	0.122383	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	3,310,053	32,443,350	35,753,403	0.011293	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,600,208	19,526,304	23,126,512	0.152350	0.000000
57.00	05700	CT SCAN	8,864,383	37,354,859	46,219,242	0.025021	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,948,303	15,999,151	17,947,454	0.112438	0.000000
60.00	06000	LABORATORY	15,399,663	24,513,814	39,913,477	0.120408	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,177,503	213,576	1,391,079	0.157550	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,934,708	10,694,388	12,629,096	0.125036	0.000000
65.00	06500	RESPIRATORY THERAPY	6,598,380	857,895	7,456,275	0.145885	0.000000
66.00	06600	PHYSICAL THERAPY	4,479,560	1,835,670	6,315,230	0.351920	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,248,453	271,429	2,519,882	0.318207	0.000000
68.00	06800	SPEECH PATHOLOGY	779,129	258,494	1,037,623	0.320906	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	86,167	35,014	121,181	0.011759	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,090,956	20,189,620	26,280,576	0.348057	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,988,388	72,294,202	79,282,590	0.208554	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	10,105,697	17,763,120	27,868,817	0.208649	0.000000
74.00	07400	RENAL DIALYSIS	24	11,172,267	11,172,291	0.128360	0.000000
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000
76.01	03560	PULMONARY FUNCTION TESTING	728,109	202,565	930,674	0.067010	0.000000
76.02	03340	GASTRO INTESTINAL SERVICES	926,444	348,892	1,275,336	0.079407	0.000000
76.03	03140	CARDIOLOGY	6,242,505	8,335,444	14,577,949	0.066289	0.000000
76.97	07697	CARDIAC REHABILITATION	0	1,370,669	1,370,669	0.660511	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,346,088	14,931,802	16,277,890	0.202715	0.000000
91.00	09100	EMERGENCY	6,942,504	33,306,410	40,248,914	0.083786	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	630,021	4,618,535	5,248,556	0.456148	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	152,213,149	483,540,091	635,753,240		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	152,213,149	483,540,091	635,753,240		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.143514			50.00
51.00	05100	RECOVERY ROOM	0.122383			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.011293			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152350			54.00
57.00	05700	CT SCAN	0.025021			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112438			58.00
60.00	06000	LABORATORY	0.120408			60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.157550			63.00
64.00	06400	INTRAVENOUS THERAPY	0.125036			64.00
65.00	06500	RESPIRATORY THERAPY	0.145885			65.00
66.00	06600	PHYSICAL THERAPY	0.351920			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.318207			67.00
68.00	06800	SPEECH PATHOLOGY	0.320906			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.011759			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.348057			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208554			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208649			73.00
74.00	07400	RENAL DIALYSIS	0.128360			74.00
76.00	03950	ANCILLARY	0.000000			76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.067010			76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.079407			76.02
76.03	03140	CARDIOLOGY	0.066289			76.03
76.97	07697	CARDIAC REHABILITATION	0.660511			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.202715			90.00
91.00	09100	EMERGENCY	0.083786			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.456148			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
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: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 7:51 am

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE			
						Disallowance			
			1.00	2.00	3.00	4.00		5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,963,929		9,963,929		0	9,963,929	30.00
31.00	03100	INTENSIVE CARE UNIT	2,141,409		2,141,409		0	2,141,409	31.00
40.00	04000	SUBPROVIDER - IPF	3,580,201		3,580,201		0	3,580,201	40.00
43.00	04300	NURSERY	0		0		0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,253,520		4,253,520		0	4,253,520	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	19,652,239		19,652,239		0	19,652,239	50.00
51.00	05100	RECOVERY ROOM	3,850,804		3,850,804		0	3,850,804	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0		0	0	52.00
53.00	05300	ANESTHESIOLOGY	403,772		403,772		0	403,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523,323		3,523,323		0	3,523,323	54.00
57.00	05700	CT SCAN	1,156,447		1,156,447		0	1,156,447	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,017,970		2,017,970		0	2,017,970	58.00
60.00	06000	LABORATORY	4,805,917		4,805,917		0	4,805,917	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	219,164		219,164		0	219,164	63.00
64.00	06400	INTRAVENOUS THERAPY	1,579,091		1,579,091		0	1,579,091	64.00
65.00	06500	RESPIRATORY THERAPY	1,087,757	0	1,087,757		0	1,087,757	65.00
66.00	06600	PHYSICAL THERAPY	2,222,455	0	2,222,455		0	2,222,455	66.00
67.00	06700	OCCUPATIONAL THERAPY	801,843	0	801,843		0	801,843	67.00
68.00	06800	SPEECH PATHOLOGY	332,979	0	332,979		0	332,979	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,425		1,425		0	1,425	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,147,133		9,147,133		0	9,147,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,534,707		16,534,707		0	16,534,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,814,801		5,814,801		0	5,814,801	73.00
74.00	07400	RENAL DIALYSIS	1,434,080		1,434,080		0	1,434,080	74.00
76.00	03950	ANCILLARY	0		0		0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,364		62,364		0	62,364	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	101,271		101,271		0	101,271	76.02
76.03	03140	CARDIOLOGY	966,356		966,356		0	966,356	76.03
76.97	07697	CARDIAC REHABILITATION	905,342		905,342		0	905,342	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,299,766		3,299,766		0	3,299,766	90.00
91.00	09100	EMERGENCY	3,372,293		3,372,293		0	3,372,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,394,119		2,394,119			2,394,119	92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0		0			0	101.00
200.00		Subtotal (see instructions)	105,626,477	0	105,626,477		0	105,626,477	200.00
201.00		Less Observation Beds	2,394,119		2,394,119			2,394,119	201.00
202.00		Total (see instructions)	103,232,358	0	103,232,358		0	103,232,358	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 7:51 am

			Title XIX		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	26,819,403		26,819,403		30.00
31.00	03100	INTENSIVE CARE UNIT	5,817,755		5,817,755		31.00
40.00	04000	SUBPROVIDER - IPF	10,176,478		10,176,478		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,573,135		5,573,135		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,806,807	126,129,662	136,936,469	0.143514	0.000000
51.00	05100	RECOVERY ROOM	2,592,325	28,872,959	31,465,284	0.122383	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	3,310,053	32,443,350	35,753,403	0.011293	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,600,208	19,526,304	23,126,512	0.152350	0.000000
57.00	05700	CT SCAN	8,864,383	37,354,859	46,219,242	0.025021	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,948,303	15,999,151	17,947,454	0.112438	0.000000
60.00	06000	LABORATORY	15,399,663	24,513,814	39,913,477	0.120408	0.000000
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,177,503	213,576	1,391,079	0.157550	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,934,708	10,694,388	12,629,096	0.125036	0.000000
65.00	06500	RESPIRATORY THERAPY	6,598,380	857,895	7,456,275	0.145885	0.000000
66.00	06600	PHYSICAL THERAPY	4,479,560	1,835,670	6,315,230	0.351920	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,248,453	271,429	2,519,882	0.318207	0.000000
68.00	06800	SPEECH PATHOLOGY	779,129	258,494	1,037,623	0.320906	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	86,167	35,014	121,181	0.011759	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,090,956	20,189,620	26,280,576	0.348057	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,988,388	72,294,202	79,282,590	0.208554	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	10,105,697	17,763,120	27,868,817	0.208649	0.000000
74.00	07400	RENAL DIALYSIS	24	11,172,267	11,172,291	0.128360	0.000000
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000
76.01	03560	PULMONARY FUNCTION TESTING	728,109	202,565	930,674	0.067010	0.000000
76.02	03340	GASTRO INTESTINAL SERVICES	926,444	348,892	1,275,336	0.079407	0.000000
76.03	03140	CARDIOLOGY	6,242,505	8,335,444	14,577,949	0.066289	0.000000
76.97	07697	CARDIAC REHABILITATION	0	1,370,669	1,370,669	0.660511	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,346,088	14,931,802	16,277,890	0.202715	0.000000
91.00	09100	EMERGENCY	6,942,504	33,306,410	40,248,914	0.083786	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	630,021	4,618,535	5,248,556	0.456148	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
200.00		Subtotal (see instructions)	152,213,149	483,540,091	635,753,240		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	152,213,149	483,540,091	635,753,240		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.143514		50.00
51.00	05100	RECOVERY ROOM	0.122383		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.011293		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152350		54.00
57.00	05700	CT SCAN	0.025021		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112438		58.00
60.00	06000	LABORATORY	0.120408		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.157550		63.00
64.00	06400	INTRAVENOUS THERAPY	0.125036		64.00
65.00	06500	RESPIRATORY THERAPY	0.145885		65.00
66.00	06600	PHYSICAL THERAPY	0.351920		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.318207		67.00
68.00	06800	SPEECH PATHOLOGY	0.320906		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.011759		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.348057		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208554		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208649		73.00
74.00	07400	RENAL DIALYSIS	0.128360		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.067010		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.079407		76.02
76.03	03140	CARDIOLOGY	0.066289		76.03
76.97	07697	CARDIAC REHABILITATION	0.660511		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.202715		90.00
91.00	09100	EMERGENCY	0.083786		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.456148		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet C
Part II
Date/Time Prepared:
5/24/2022 7:51 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,652,239	761,953	18,890,286	0	0	50.00
51.00	05100	RECOVERY ROOM	3,850,804	164,339	3,686,465	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	403,772	204,003	199,769	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523,323	348,173	3,175,150	0	0	54.00
57.00	05700	CT SCAN	1,156,447	252,701	903,746	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,017,970	692,671	1,325,299	0	0	58.00
60.00	06000	LABORATORY	4,805,917	243,637	4,562,280	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	219,164	894	218,270	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,579,091	64,217	1,514,874	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,087,757	69,221	1,018,536	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,222,455	117,059	2,105,396	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	801,843	39,494	762,349	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	332,979	10,772	322,207	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,425	35	1,390	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,147,133	127,686	9,019,447	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,534,707	110,726	16,423,981	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,814,801	75,958	5,738,843	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,434,080	270,224	1,163,856	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,364	3,710	58,654	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	101,271	31,474	69,797	0	0	76.02
76.03	03140	CARDIOLOGY	966,356	89,281	877,075	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	905,342	108,880	796,462	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,299,766	277,672	3,022,094	0	0	90.00
91.00	09100	EMERGENCY	3,372,293	270,195	3,102,098	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,394,119	202,025	2,192,094	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	85,687,418	4,537,000	81,150,418	0	0	200.00
201.00		Less Observation Beds	2,394,119	202,025	2,192,094	0	0	201.00
202.00		Total (line 200 minus line 201)	83,293,299	4,334,975	78,958,324	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,652,239	136,936,469	0.143514	50.00
51.00	05100	RECOVERY ROOM	3,850,804	31,465,284	0.122383	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	403,772	35,753,403	0.011293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523,323	23,126,512	0.152350	54.00
57.00	05700	CT SCAN	1,156,447	46,219,242	0.025021	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,017,970	17,947,454	0.112438	58.00
60.00	06000	LABORATORY	4,805,917	39,913,477	0.120408	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	219,164	1,391,079	0.157550	63.00
64.00	06400	INTRAVENOUS THERAPY	1,579,091	12,629,096	0.125036	64.00
65.00	06500	RESPIRATORY THERAPY	1,087,757	7,456,275	0.145885	65.00
66.00	06600	PHYSICAL THERAPY	2,222,455	6,315,230	0.351920	66.00
67.00	06700	OCCUPATIONAL THERAPY	801,843	2,519,882	0.318207	67.00
68.00	06800	SPEECH PATHOLOGY	332,979	1,037,623	0.320906	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,425	121,181	0.011759	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,147,133	26,280,576	0.348057	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,534,707	79,282,590	0.208554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,814,801	27,868,817	0.208649	73.00
74.00	07400	RENAL DIALYSIS	1,434,080	11,172,291	0.128360	74.00
76.00	03950	ANCILLARY	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,364	930,674	0.067010	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	101,271	1,275,336	0.079407	76.02
76.03	03140	CARDIOLOGY	966,356	14,577,949	0.066289	76.03
76.97	07697	CARDIAC REHABILITATION	905,342	1,370,669	0.660511	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,299,766	16,277,890	0.202715	90.00
91.00	09100	EMERGENCY	3,372,293	40,248,914	0.083786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,394,119	5,248,556	0.456148	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000	101.00
200.00		Subtotal (sum of lines 50 thru 199)	85,687,418	587,366,469		200.00
201.00		Less Observation Beds	2,394,119	0		201.00
202.00		Total (line 200 minus line 201)	83,293,299	587,366,469		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/24/2022 7:51 am

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	840,797	0	840,797	12,577	66.85	30.00	
31.00	INTENSIVE CARE UNIT	198,638		198,638	1,096	181.24	31.00	
40.00	SUBPROVIDER - IPF	379,676	0	379,676	4,035	94.10	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	559,387		559,387	5,600	99.89	44.00	
200.00	Total (lines 30 through 199)	1,978,498		1,978,498	23,308		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	4,524	302,429					30.00
31.00	INTENSIVE CARE UNIT	583	105,663					31.00
40.00	SUBPROVIDER - IPF	2,350	221,135					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	3,842	383,777					44.00
200.00	Total (lines 30 through 199)	11,299	1,013,004					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/24/2022 7:51 am		
				Title XVIII		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	761,953	136,936,469	0.005564	4,692,157	26,107	50.00
51.00	05100	RECOVERY ROOM	164,339	31,465,284	0.005223	1,091,133	5,699	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	204,003	35,753,403	0.005706	1,403,644	8,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,173	23,126,512	0.015055	1,763,458	26,549	54.00
57.00	05700	CT SCAN	252,701	46,219,242	0.005467	4,006,550	21,904	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	692,671	17,947,454	0.038594	836,095	32,268	58.00
60.00	06000	LABORATORY	243,637	39,913,477	0.006104	6,452,925	39,389	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	894	1,391,079	0.000643	597,070	384	63.00
64.00	06400	INTRAVENOUS THERAPY	64,217	12,629,096	0.005085	829,477	4,218	64.00
65.00	06500	RESPIRATORY THERAPY	69,221	7,456,275	0.009284	2,390,713	22,195	65.00
66.00	06600	PHYSICAL THERAPY	117,059	6,315,230	0.018536	634,174	11,755	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,494	2,519,882	0.015673	205,225	3,216	67.00
68.00	06800	SPEECH PATHOLOGY	10,772	1,037,623	0.010381	162,069	1,682	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35	121,181	0.000289	37,052	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,686	26,280,576	0.004859	3,018,983	14,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,726	79,282,590	0.001397	2,857,592	3,992	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,958	27,868,817	0.002726	4,062,014	11,073	73.00
74.00	07400	RENAL DIALYSIS	270,224	11,172,291	0.024187	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	3,710	930,674	0.003986	321,205	1,280	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	31,474	1,275,336	0.024679	395,312	9,756	76.02
76.03	03140	CARDIOLOGY	89,281	14,577,949	0.006124	2,878,528	17,628	76.03
76.97	07697	CARDIAC REHABILITATION	108,880	1,370,669	0.079436	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	277,672	16,277,890	0.017058	521,346	8,893	90.00
91.00	09100	EMERGENCY	270,195	40,248,914	0.006713	3,245,547	21,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,025	5,248,556	0.038492	360,228	13,866	92.00
200.00		Total (lines 50 through 199)	4,537,000	587,366,469		42,762,497	306,330	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/24/2022 7:51 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	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	
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	40.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	12,577	0.00	4,524	30.00		
31.00	03100	INTENSIVE CARE UNIT			0	1,096	0.00	583	31.00		
40.00	04000	SUBPROVIDER - IPF	0		0	4,035	0.00	2,350	40.00		
43.00	04300	NURSERY			0	0	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY			0	5,600	0.00	3,842	44.00		
200.00		Total (lines 30 through 199)			0	23,308		11,299	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0					30.00		
31.00	03100	INTENSIVE CARE UNIT		0					31.00		
40.00	04000	SUBPROVIDER - IPF		0					40.00		
43.00	04300	NURSERY		0					43.00		
44.00	04400	SKILLED NURSING FACILITY		0					44.00		
200.00		Total (lines 30 through 199)		0					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
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: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

				Title XVIII		Hospital	PPS		
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	136,936,469	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	31,465,284	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	35,753,403	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,126,512	0.000000	54.00	
57.00	05700	CT SCAN	0	0	0	46,219,242	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,947,454	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	39,913,477	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,391,079	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,629,096	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,456,275	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	6,315,230	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,519,882	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,037,623	0.000000	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	121,181	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,280,576	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,282,590	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,868,817	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	11,172,291	0.000000	74.00	
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00	
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	930,674	0.000000	76.01	
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	1,275,336	0.000000	76.02	
76.03	03140	CARDIOLOGY	0	0	0	14,577,949	0.000000	76.03	
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,370,669	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	16,277,890	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	40,248,914	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,248,556	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	587,366,469		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,692,157	0	34,508,474	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	1,091,133	0	7,499,275	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	1,403,644	0	7,817,495	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,763,458	0	4,714,805	0	54.00	
57.00	05700	CT SCAN	0.000000	4,006,550	0	11,216,171	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	836,095	0	4,625,652	0	58.00	
60.00	06000	LABORATORY	0.000000	6,452,925	0	3,996,531	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	597,070	0	82,386	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	829,477	0	2,505,807	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	2,390,713	0	293,200	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	634,174	0	243,911	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	205,225	0	50,296	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	162,069	0	18,802	0	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	37,052	0	8,310	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,018,983	0	5,243,843	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,857,592	0	24,266,319	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,062,014	0	4,706,270	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00	
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	321,205	0	79,567	0	76.01	
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	395,312	0	102,374	0	76.02	
76.03	03140	CARDIOLOGY	0.000000	2,878,528	0	2,433,926	0	76.03	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	547,560	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	521,346	0	2,044,294	0	90.00	
91.00	09100	EMERGENCY	0.000000	3,245,547	0	7,194,345	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	360,228	0	940,123	0	92.00	
200.00		Total (lines 50 through 199)		42,762,497	0	125,139,736	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/24/2022 7:51 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.143514	34,508,474	0	0	4,952,449	50.00
51.00	05100	RECOVERY ROOM		0.122383	7,499,275	0	0	917,784	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.011293	7,817,495	0	0	88,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.152350	4,714,805	0	0	718,301	54.00
57.00	05700	CT SCAN		0.025021	11,216,171	0	0	280,640	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.112438	4,625,652	0	0	520,099	58.00
60.00	06000	LABORATORY		0.120408	3,996,531	9,972	0	481,214	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.157550	82,386	0	0	12,980	63.00
64.00	06400	INTRAVENOUS THERAPY		0.125036	2,505,807	0	0	313,316	64.00
65.00	06500	RESPIRATORY THERAPY		0.145885	293,200	0	0	42,773	65.00
66.00	06600	PHYSICAL THERAPY		0.351920	243,911	0	0	85,837	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.318207	50,296	0	0	16,005	67.00
68.00	06800	SPEECH PATHOLOGY		0.320906	18,802	0	0	6,034	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.011759	8,310	0	0	98	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.348057	5,243,843	0	0	1,825,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.208554	24,266,319	0	0	5,060,838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.208649	4,706,270	1,191	8,946	981,959	73.00
74.00	07400	RENAL DIALYSIS		0.128360	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.067010	79,567	0	0	5,332	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.079407	102,374	0	0	8,129	76.02
76.03	03140	CARDIOLOGY		0.066289	2,433,926	0	0	161,343	76.03
76.97	07697	CARDIAC REHABILITATION		0.660511	547,560	0	0	361,669	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.202715	2,044,294	78	78	414,409	90.00
91.00	09100	EMERGENCY		0.083786	7,194,345	0	0	602,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.456148	940,123	0	0	428,835	92.00
200.00		Subtotal (see instructions)			125,139,736	11,241	9,024	18,286,268	200.00
201.00		Less PBP Clinic Lab. Services-Program				0	0		201.00
201.00		Only Charges							
202.00		Net Charges (line 200 - line 201)			125,139,736	11,241	9,024	18,286,268	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0013		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/24/2022 7:51 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	1,201	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	249	1,867		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16	16		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)	1,466	1,883		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,466	1,883		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:

Worksheet D

Component CCN: 14-S013

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/24/2022 7:51 am

Title XVIII

Subprovider -
IPF

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	761,953	136,936,469	0.005564	0	0	50.00
51.00	05100	RECOVERY ROOM	164,339	31,465,284	0.005223	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	204,003	35,753,403	0.005706	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,173	23,126,512	0.015055	76,800	1,156	54.00
57.00	05700	CT SCAN	252,701	46,219,242	0.005467	290,885	1,590	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	692,671	17,947,454	0.038594	19,580	756	58.00
60.00	06000	LABORATORY	243,637	39,913,477	0.006104	590,949	3,607	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	894	1,391,079	0.000643	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	64,217	12,629,096	0.005085	18,209	93	64.00
65.00	06500	RESPIRATORY THERAPY	69,221	7,456,275	0.009284	259,102	2,406	65.00
66.00	06600	PHYSICAL THERAPY	117,059	6,315,230	0.018536	84,366	1,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,494	2,519,882	0.015673	12,327	193	67.00
68.00	06800	SPEECH PATHOLOGY	10,772	1,037,623	0.010381	17,341	180	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35	121,181	0.000289	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,686	26,280,576	0.004859	31,504	153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,726	79,282,590	0.001397	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,958	27,868,817	0.002726	150,109	409	73.00
74.00	07400	RENAL DIALYSIS	270,224	11,172,291	0.024187	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	3,710	930,674	0.003986	5,626	22	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	31,474	1,275,336	0.024679	0	0	76.02
76.03	03140	CARDIOLOGY	89,281	14,577,949	0.006124	76,618	469	76.03
76.97	07697	CARDIAC REHABILITATION	108,880	1,370,669	0.079436	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	277,672	16,277,890	0.017058	33,127	565	90.00
91.00	09100	EMERGENCY	270,195	40,248,914	0.006713	260,773	1,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,248,556	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,334,975	587,366,469		1,927,316	14,914	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
			Title XVIII		Subprovider - IPF		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	136,936,469	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,465,284	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35,753,403	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,126,512	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	46,219,242	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,947,454	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	39,913,477	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,391,079	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,629,096	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,456,275	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,315,230	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,519,882	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,037,623	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	121,181	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,280,576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,282,590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,868,817	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	11,172,291	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	930,674	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	1,275,336	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	14,577,949	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,370,669	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,277,890	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,248,914	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,248,556	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	587,366,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
				Title XVIII		Subprovider - IPF		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	76,800	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	290,885	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	19,580	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	590,949	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	18,209	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	259,102	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	84,366	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	12,327	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	17,341	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	31,504	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	150,109	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	5,626	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0.000000	76,618	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	33,127	0	787	0	90.00
91.00	09100	EMERGENCY		0.000000	260,773	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)			1,927,316	0	787	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/24/2022 7:51 am	
				Title XVIII		Subprovider - IPF		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	0.143514	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.122383	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.011293	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152350	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0.025021	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112438	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.120408	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.157550	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.125036	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.145885	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.351920	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.318207	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.320906	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.011759	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.348057	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208554	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208649	0	0	0	1,444	0	73.00
74.00	07400	RENAL DIALYSIS	0.128360	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.067010	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.079407	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.066289	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.660511	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.202715	787	0	0	0	160	90.00
91.00	09100	EMERGENCY	0.083786	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.456148	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		787	0	0	1,444	160	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		787	0	0	1,444	160	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013

Period:

Worksheet D

Component CCN: 14-S013

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
5/24/2022 7:51 am

Title XVIII

Subprovider -
IPF

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	301	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	76.03
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)	0	301	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	301	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/24/2022 7:51 am

			Title XIX		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	840,797	0	840,797	12,577	66.85	30.00
31.00	INTENSIVE CARE UNIT	198,638		198,638	1,096	181.24	31.00
40.00	SUBPROVIDER - IPF	379,676	0	379,676	4,035	94.10	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	559,387		559,387	5,600	99.89	44.00
200.00	Total (lines 30 through 199)	1,978,498		1,978,498	23,308		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	748	50,004				
31.00	INTENSIVE CARE UNIT	64	11,599				
40.00	SUBPROVIDER - IPF	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	812	61,603				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XIX		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	761,953	136,936,469	0.005564	0	0 50.00
51.00	05100	RECOVERY ROOM	164,339	31,465,284	0.005223	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	204,003	35,753,403	0.005706	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,173	23,126,512	0.015055	0	0 54.00
57.00	05700	CT SCAN	252,701	46,219,242	0.005467	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	692,671	17,947,454	0.038594	0	0 58.00
60.00	06000	LABORATORY	243,637	39,913,477	0.006104	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	894	1,391,079	0.000643	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	64,217	12,629,096	0.005085	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	69,221	7,456,275	0.009284	0	0 65.00
66.00	06600	PHYSICAL THERAPY	117,059	6,315,230	0.018536	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	39,494	2,519,882	0.015673	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	10,772	1,037,623	0.010381	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35	121,181	0.000289	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127,686	26,280,576	0.004859	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,726	79,282,590	0.001397	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,958	27,868,817	0.002726	0	0 73.00
74.00	07400	RENAL DIALYSIS	270,224	11,172,291	0.024187	0	0 74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0 76.00
76.01	03560	PULMONARY FUNCTION TESTING	3,710	930,674	0.003986	0	0 76.01
76.02	03340	GASTRO INTESTINAL SERVICES	31,474	1,275,336	0.024679	0	0 76.02
76.03	03140	CARDIOLOGY	89,281	14,577,949	0.006124	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	108,880	1,370,669	0.079436	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	277,672	16,277,890	0.017058	0	0 90.00
91.00	09100	EMERGENCY	270,195	40,248,914	0.006713	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,025	5,248,556	0.038492	0	0 92.00
200.00		Total (lines 50 through 199)	4,537,000	587,366,469		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/24/2022 7:51 am	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	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	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	12,577	0.00	748	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,096	0.00	64	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,035	0.00	0	40.00		
43.00	04300	NURSERY	0	0	0	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	5,600	0.00	0	44.00		
200.00		Total (lines 30 through 199)	0	0	23,308	0.00	812	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
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: 14-0013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
			Title XIX		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	136,936,469	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,465,284	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35,753,403	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,126,512	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	46,219,242	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	17,947,454	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	39,913,477	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,391,079	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,629,096	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,456,275	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,315,230	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,519,882	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,037,623	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	121,181	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,280,576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,282,590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,868,817	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	11,172,291	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	930,674	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	1,275,336	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	14,577,949	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,370,669	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,277,890	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	40,248,914	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,248,556	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	587,366,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XIX			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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	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)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/24/2022 7:51 am	
				Title XIX		Subprovider - IPF		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		761,953	136,936,469	0.005564	0	0	50.00
51.00	05100	RECOVERY ROOM		164,339	31,465,284	0.005223	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY		204,003	35,753,403	0.005706	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		348,173	23,126,512	0.015055	0	0	54.00
57.00	05700	CT SCAN		252,701	46,219,242	0.005467	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		692,671	17,947,454	0.038594	0	0	58.00
60.00	06000	LABORATORY		243,637	39,913,477	0.006104	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		894	1,391,079	0.000643	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		64,217	12,629,096	0.005085	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		69,221	7,456,275	0.009284	0	0	65.00
66.00	06600	PHYSICAL THERAPY		117,059	6,315,230	0.018536	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		39,494	2,519,882	0.015673	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		10,772	1,037,623	0.010381	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		35	121,181	0.000289	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		127,686	26,280,576	0.004859	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		110,726	79,282,590	0.001397	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		75,958	27,868,817	0.002726	0	0	73.00
74.00	07400	RENAL DIALYSIS		270,224	11,172,291	0.024187	0	0	74.00
76.00	03950	ANCILLARY		0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		3,710	930,674	0.003986	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		31,474	1,275,336	0.024679	0	0	76.02
76.03	03140	CARDIOLOGY		89,281	14,577,949	0.006124	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		108,880	1,370,669	0.079436	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		277,672	16,277,890	0.017058	0	0	90.00
91.00	09100	EMERGENCY		270,195	40,248,914	0.006713	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	5,248,556	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		4,334,975	587,366,469		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	ANCILLARY		0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0	0	0	0	0	76.03
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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
				Title XIX		Subprovider - IPF		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	136,936,469	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	31,465,284	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	35,753,403	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,126,512	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	46,219,242	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	17,947,454	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	39,913,477	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,391,079	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	12,629,096	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	7,456,275	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,315,230	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,519,882	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,037,623	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	121,181	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	26,280,576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	79,282,590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	27,868,817	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	11,172,291	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	930,674	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	1,275,336	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	14,577,949	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,370,669	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,277,890	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	40,248,914	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	5,248,556	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	587,366,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
				Title XIX		Subprovider - IPF		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	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY		0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	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)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013
Component CCN: 14-5579

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

			Title XIX		Skilled Nursing Facility	PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03950	ANCILLARY	0	0	0	0	0 76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0 76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0 76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0 76.03
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: 14-0013 Component CCN: 14-5579		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/24/2022 7:51 am	
				Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	136,936,469	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	31,465,284	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	35,753,403	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,126,512	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	46,219,242	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	17,947,454	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	39,913,477	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	1,391,079	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	12,629,096	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	7,456,275	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,315,230	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,519,882	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,037,623	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	121,181	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	26,280,576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	79,282,590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	27,868,817	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	11,172,291	0.000000	74.00
76.00	03950	ANCILLARY		0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING		0	0	0	930,674	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0	0	0	1,275,336	0.000000	76.02
76.03	03140	CARDIOLOGY		0	0	0	14,577,949	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,370,669	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,277,890	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	40,248,914	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	5,248,556	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	587,366,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0013
Component CCN: 14-5579

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/24/2022 7:51 am

				Title XIX		Skilled Nursing Facility	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0 54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0 58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0.000000	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0 74.00
76.00	03950	ANCILLARY		0.000000	0	0	0	0 76.00
76.01	03560	PULMONARY FUNCTION TESTING		0.000000	0	0	0	0 76.01
76.02	03340	GASTRO INTESTINAL SERVICES		0.000000	0	0	0	0 76.02
76.03	03140	CARDIOLOGY		0.000000	0	0	0	0 76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC		0.000000	0	0	0	0 90.00
91.00	09100	EMERGENCY		0.000000	0	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)			0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Hospital	PPS
Cost Center Description				
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,577	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,577	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)		9,555	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)		4,524	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)		9,963,929	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)		9,963,929	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)		9,963,929	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)		792.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,584,049	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)		3,584,049	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/24/2022 7:51 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	2,141,409	1,096	1,953.84	583	1,139,089
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)					6,230,098
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,953,236
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					408,092
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					306,330
52.00	Total Program excludable cost (sum of lines 50 and 51)					714,422
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,238,814
	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)					3,022
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					792.23
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,394,119

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	840,797	9,963,929	0.084384	2,394,119	202,025
91.00	Nursing Program cost	0	9,963,929	0.000000	2,394,119	0
92.00	Allied health cost	0	9,963,929	0.000000	2,394,119	0
93.00	All other Medical Education	0	9,963,929	0.000000	2,394,119	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Subprovider - IPF	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)		4,035	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,035	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)		4,035	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)		2,350	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)		3,580,201	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)		3,580,201	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)		3,580,201	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)		887.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,085,132	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,085,132	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-S013		Date/Time Prepared: 5/24/2022 7:51 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						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)					247,894	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,333,026	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					221,135	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,914	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					236,049	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,096,977	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII		Subprovider - IPF	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	379,676	3,580,201	0.106049	0	0 90.00
91.00	Nursing Program cost	0	3,580,201	0.000000	0	0 91.00
92.00	Allied health cost	0	3,580,201	0.000000	0	0 92.00
93.00	All other Medical Education	0	3,580,201	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,600	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,600	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,600	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)		3,842	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)		4,253,520	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)		4,253,520	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)		4,253,520	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-5579		Date/Time Prepared: 5/24/2022 7:51 am	
				Title XVIII		Skilled Nursing Facility	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						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						4,253,520 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						759.56 71.00
72.00	Program routine service cost (line 9 x line 71)						2,918,230 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						2,918,230 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						2,918,230 83.00
84.00	Program inpatient ancillary services (see instructions)						1,724,183 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						4,642,413 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am	
			Title XVIII		Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am
		Title XIX	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,577	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,577	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)		9,555	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)		748	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)		9,963,929	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)		9,963,929	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)		9,963,929	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)		792.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		592,588	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)		592,588	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XIX		Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	2,141,409	1,096	1,953.84	64	125,046
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)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					717,634
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					61,603
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					61,603
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					656,031
	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)					3,022
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					792.23
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,394,119

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	840,797	9,963,929	0.084384	2,394,119	202,025
91.00	Nursing Program cost	0	9,963,929	0.000000	2,394,119	0
92.00	Allied health cost	0	9,963,929	0.000000	2,394,119	0
93.00	All other Medical Education	0	9,963,929	0.000000	2,394,119	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am
		Title XIX	Subprovider - IPF	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)		4,035	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,035	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)		4,035	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)		0	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)		3,580,201	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)		3,580,201	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)		3,580,201	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)		887.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-S013		Date/Time Prepared: 5/24/2022 7:51 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am	
		Title XIX		Subprovider - IPF	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	379,676	3,580,201	0.106049	0	0	90.00
91.00 Nursing Program cost	0	3,580,201	0.000000	0	0	91.00
92.00 Allied health cost	0	3,580,201	0.000000	0	0	92.00
93.00 All other Medical Education	0	3,580,201	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am
		Title XIX	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,600	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,600	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,600	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)		0	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)		4,253,520	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)		4,253,520	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)		4,253,520	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1		
				Component CCN: 14-5579		Date/Time Prepared: 5/24/2022 7:51 am		
				Title XIX		Skilled Nursing Facility	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							43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							54.00
55.00	Target amount per discharge							55.00
56.00	Target amount (line 54 x line 55)							56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00
58.00	Bonus payment (see instructions)							58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00	Relief payment (see instructions)							62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						4,253,520	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						759.56	71.00
72.00	Program routine service cost (line 9 x line 71)						0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						559,387	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						99.89	76.00
77.00	Program capital-related costs (line 9 x line 76)						0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00
81.00	Inpatient routine service cost per diem limitation						0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)						0	83.00
84.00	Program inpatient ancillary services (see instructions)						0	84.00
85.00	Utilization review - physician compensation (see instructions)						0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0013 Component CCN: 14-5579		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/24/2022 7:51 am	
			Title XIX		Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 7:51 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		12,849,048		30.00
31.00	03100	INTENSIVE CARE UNIT		3,160,025		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.143514	4,692,157	673,390	50.00
51.00	05100	RECOVERY ROOM	0.122383	1,091,133	133,536	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.011293	1,403,644	15,851	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152350	1,763,458	268,663	54.00
57.00	05700	CT SCAN	0.025021	4,006,550	100,248	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112438	836,095	94,009	58.00
60.00	06000	LABORATORY	0.120408	6,452,925	776,984	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.157550	597,070	94,068	63.00
64.00	06400	INTRAVENOUS THERAPY	0.125036	829,477	103,714	64.00
65.00	06500	RESPIRATORY THERAPY	0.145885	2,390,713	348,769	65.00
66.00	06600	PHYSICAL THERAPY	0.351920	634,174	223,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.318207	205,225	65,304	67.00
68.00	06800	SPEECH PATHOLOGY	0.320906	162,069	52,009	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.011759	37,052	436	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.348057	3,018,983	1,050,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208554	2,857,592	595,962	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208649	4,062,014	847,535	73.00
74.00	07400	RENAL DIALYSIS	0.128360	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.067010	321,205	21,524	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.079407	395,312	31,391	76.02
76.03	03140	CARDIOLOGY	0.066289	2,878,528	190,815	76.03
76.97	07697	CARDIAC REHABILITATION	0.660511	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.202715	521,346	105,685	90.00
91.00	09100	EMERGENCY	0.083786	3,245,547	271,931	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.456148	360,228	164,317	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		42,762,497	6,230,098	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)		42,762,497		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		5,923,780		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.143514	0	0	50.00
51.00	05100 RECOVERY ROOM	0.122383	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.011293	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.152350	76,800	11,700	54.00
57.00	05700 CT SCAN	0.025021	290,885	7,278	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112438	19,580	2,202	58.00
60.00	06000 LABORATORY	0.120408	590,949	71,155	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.157550	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.125036	18,209	2,277	64.00
65.00	06500 RESPIRATORY THERAPY	0.145885	259,102	37,799	65.00
66.00	06600 PHYSICAL THERAPY	0.351920	84,366	29,690	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.318207	12,327	3,923	67.00
68.00	06800 SPEECH PATHOLOGY	0.320906	17,341	5,565	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.011759	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.348057	31,504	10,965	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.208554	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.208649	150,109	31,320	73.00
74.00	07400 RENAL DIALYSIS	0.128360	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.067010	5,626	377	76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.079407	0	0	76.02
76.03	03140 CARDIOLOGY	0.066289	76,618	5,079	76.03
76.97	07697 CARDIAC REHABILITATION	0.660511	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.202715	33,127	6,715	90.00
91.00	09100 EMERGENCY	0.083786	260,773	21,849	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.456148	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,927,316	247,894	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,927,316		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.143514	0	0	50.00
51.00	05100 RECOVERY ROOM	0.122383	5,220	639	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.011293	6,000	68	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.152350	79,813	12,160	54.00
57.00	05700 CT SCAN	0.025021	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112438	0	0	58.00
60.00	06000 LABORATORY	0.120408	674,672	81,236	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.157550	17,723	2,792	63.00
64.00	06400 INTRAVENOUS THERAPY	0.125036	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.145885	1,286,939	187,745	65.00
66.00	06600 PHYSICAL THERAPY	0.351920	2,262,210	796,117	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.318207	1,308,619	416,412	67.00
68.00	06800 SPEECH PATHOLOGY	0.320906	305,523	98,044	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.011759	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.348057	7,853	2,733	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.208554	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.208649	520,818	108,668	73.00
74.00	07400 RENAL DIALYSIS	0.128360	0	0	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03560 PULMONARY FUNCTION TESTING	0.067010	3,169	212	76.01
76.02	03340 GASTRO INTESTINAL SERVICES	0.079407	0	0	76.02
76.03	03140 CARDIOLOGY	0.066289	8,188	543	76.03
76.97	07697 CARDIAC REHABILITATION	0.660511	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.202715	82,946	16,814	90.00
91.00	09100 EMERGENCY	0.083786	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.456148	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,569,693	1,724,183	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		6,569,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A
Date/Time Prepared:
5/24/2022 7:51 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			6,794,237	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,599,160	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)			33,210	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			4,168	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)			100.72	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)			3.24	30.00
31.00	Percentage of Medicaid patient days (see instructions)			7.54	31.00
32.00	Sum of lines 30 and 31			10.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)			0.00	33.00
34.00	Disproportionate share adjustment (see instructions)			0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)				46.00
47.00	Subtotal (see instructions)	9,430,775			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			9,430,775	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			731,813	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			26,812	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)			10,189,400	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			10,189,400	61.00
62.00	Deductibles billed to program beneficiaries			1,248,692	62.00
63.00	Coinsurance billed to program beneficiaries			15,487	63.00
64.00	Allowable bad debts (see instructions)			61,427	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			39,928	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,541	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			8,965,149	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			121,298	70.93
70.94	HRR adjustment amount (see instructions)			-20,963	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,065,484	71.00	
71.01	Sequestration adjustment (see instructions)		0	71.01	
71.02	Demonstration payment adjustment amount after sequestration		176,410	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		8,922,139	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-33,065	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2022 7:51 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,794,237	0	6,794,237		6,794,237
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,599,160	0		2,599,160	2,599,160
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	33,210	0	33,210		33,210
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,168	0		4,168	4,168
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	9,430,775	0	6,827,447	2,603,328	9,430,775
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,430,775	0	6,827,447	2,603,328	9,430,775
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	731,813	0	532,657	199,156	731,813

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2022 7:51 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	26,812	0	21,310	5,502	26,812	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,381,414	2,807,986	10,189,400	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	714,948	0	520,183	194,765	714,948	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,136	0	1,030	106	1,136	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0220	0.0220	0.0220	0.0220		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	15,729	0	11,444	4,285	15,729	25.00
26.00	Total prospective capital payments (see instructions)	12.00	731,813	0	532,657	199,156	731,813	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/24/2022 7:51 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,794,237	6,794,237		6,794,237	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,599,160		2,599,160	2,599,160	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	33,210	33,210		33,210	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,168		4,168	4,168	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,430,775	6,827,447	2,603,328	9,430,775	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,430,775	6,827,447	2,603,328	9,430,775	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	731,813	532,657	199,156	731,813	16.00
17.00	Special add-on payments for new technologies	54.00	26,812	21,310	5,502	26,812	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,381,414	2,807,986	10,189,400	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/24/2022 7:51 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	714,948	520,183	194,765	714,948	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,136	1,030	106	1,136	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0220	0.0220	0.0220		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	15,729	11,444	4,285	15,729	25.00
26.00	Total prospective capital payments (see instructions)	12.00	731,813	532,657	199,156	731,813	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	121,298	121,298	0	121,298	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-20,963	-11,587	-9,376	-20,963	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,349	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,286,268	2.00
3.00	OPPS payments		15,030,291	3.00
4.00	Outlier payment (see instructions)		32,248	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,349	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		20,265	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)		20,265	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)		20,265	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		16,916	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)		3,349	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)		15,062,539	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)		2,452,373	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)		12,613,515	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)		12,613,515	30.00
31.00	Primary payer payments		2,419	31.00
32.00	Subtotal (line 30 minus line 31)		12,611,096	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)		46,463	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		30,201	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,460	36.00
37.00	Subtotal (see instructions)		12,641,297	37.00
38.00	MSP-LCC reconciliation amount from PS&R		56	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)		12,641,241	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		222,303	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		12,496,872	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)		-77,934	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: 14-0013 Component CCN: 14-S013	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		301	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		160	2.00
3.00	OPPS payments		381	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		301	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,444	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)		1,444	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)		1,444	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,143	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)		301	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)		381	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)		0	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)		682	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)		682	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		682	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		682	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		682	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		678	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		4	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/24/2022 7:51 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,948,535		12,524,995	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	10/13/2021	26,396	10/13/2021	28,123	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)		-26,396		-28,123	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)		8,922,139		12,496,872	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		33,065		77,934	6.02
7.00	Total Medicare program liability (see instructions)		8,889,074		12,418,938	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: 14-0013 Component CCN: 14-S013		Period: From 01/01/2021 To 12/31/2021		Worksheet E-1 Part I Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII		Subprovider - IPF		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						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		1,926,973		678		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,926,973		678		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		6,092		4		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,933,065		682		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: 14-0013 Component CCN: 14-5579		Period: From 01/01/2021 To 12/31/2021		Worksheet E-1 Part I Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					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		1,807,604			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,807,604			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		0			0	6.01
6.02	SETTLEMENT TO PROGRAM		1			0	6.02
7.00	Total Medicare program liability (see instructions)		1,807,603			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: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/24/2022 7:51 am	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,139,912 1.00
2.00	Net IPF PPS Outlier Payments			4,087 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	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 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	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 6.00
7.00	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 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			11.054795 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,143,999 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,143,999 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,143,999 18.00
19.00	Deductibles			158,408 19.00
20.00	Subtotal (line 18 minus line 19)			1,985,591 20.00
21.00	Coinsurance			58,618 21.00
22.00	Subtotal (line 20 minus line 21)			1,926,973 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			9,372 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			6,092 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,748 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,933,065 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,933,065 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,926,973 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			6,092 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			4,087 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
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)			2,062,051 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,062,051 4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			209,430 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			1,852,621 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			1,852,621 15.00
15.01	Sequestration adjustment (see instructions)			0 15.01
15.02	Demonstration payment adjustment amount after sequestration			45,018 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			1,807,604 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			-1 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

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

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet G

Date/Time Prepared:
5/24/2022 7:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,165,043	0	0	0	1.00
2.00	Temporary investments	1,335,481	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,298,935	0	0	0	4.00
5.00	Other receivable	17,281,554	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,494,857	0	0	0	7.00
8.00	Prepaid expenses	289,576	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	8,041,833	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	51,907,279	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,081,907	0	0	0	12.00
13.00	Land improvements	1,312,599	0	0	0	13.00
14.00	Accumulated depreciation	-6,453,397	0	0	0	14.00
15.00	Buildings	35,752,479	0	0	0	15.00
16.00	Accumulated depreciation	-53,870,914	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,323,300	0	0	0	19.00
20.00	Accumulated depreciation	-19,372,074	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	129,365,808	0	0	0	23.00
24.00	Accumulated depreciation	-55,402,672	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)	40,737,036	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	9,861,448	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	6,706,361	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,567,809	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	109,212,124	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,070,579	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,621,176	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	15,355,068	0	0	0	43.00
44.00	Other current liabilities	11,299,218	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,346,041	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,844,972	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,846,972	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,193,013	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	60,019,111				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	60,019,111	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	109,212,124	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-1

Date/Time Prepared:
5/24/2022 7:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		66,164,969		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		37,035,437				2.00
3.00	Total (sum of line 1 and line 2)		103,200,406		0		3.00
4.00	CHANGE IN UNRESTRICTED FUND BALANCE	-138,051		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-138,051		0		10.00
11.00	Subtotal (line 3 plus line 10)		103,062,355		0		11.00
12.00	CHANGE IN TEMP OR PERM REST	43,043,244		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		43,043,244		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		60,019,111		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CHANGE IN UNRESTRICTED FUND BALANCE		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN TEMP OR PERM REST		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2022 7:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	28,327,940		28,327,940	1.00
2.00	SUBPROVIDER - IPF	10,187,839		10,187,839	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	11,049,337		11,049,337	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)	49,565,116		49,565,116	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,039,609		6,039,609	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)	6,039,609		6,039,609	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,604,725		55,604,725	17.00
18.00	Ancillary services	98,514,972	0	98,514,972	18.00
19.00	Outpatient services	0	494,107,630	494,107,630	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		0	0	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)	154,119,697	494,107,630	648,227,327	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		93,383,745		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)		93,383,745		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0013

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-3

Date/Time Prepared:
5/24/2022 7:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	648,227,327	1.00
2.00	Less contractual allowances and discounts on patients' accounts	509,594,634	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,632,693	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	93,383,745	4.00
5.00	Net income from service to patients (line 3 minus line 4)	45,248,948	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	266,696	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	393,363	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	HOME OFFICE REVENUE	5,280,896	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	5,940,955	25.00
26.00	Total (line 5 plus line 25)	51,189,903	26.00
27.00	HOME OFFICE EXPENSES	14,154,466	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	14,154,466	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	37,035,437	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0013

Period:

Worksheet I-1

Component CCN: 14-2337

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 7:51 am

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	247,062	HOURS OF SERVICE	6,469.00	3.11
2.00	LICENSED PRACTICAL NURSES	42,178	HOURS OF SERVICE	1,891.00	0.91
3.00	NURSES AIDES	64	HOURS OF SERVICE	4.00	0.00
4.00	TECHNICIANS	62,865	HOURS OF SERVICE	3,450.00	1.66
5.00	SOCIAL WORKERS	30,243	HOURS OF SERVICE	1,241.00	0.60
6.00	DIETICIANS	900	HOURS OF SERVICE	31.00	0.01
7.00	PHYSICIANS	0	ACCUMULATED COST		7.00
8.00	NON-PATIENT CARE SALARY	3,199	ACCUMULATED COST		8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	386,511			9.00
10.00	EMPLOYEE BENEFITS	96,072	SALARY		10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	185,339	SQUARE FEET		11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	6,619	PERCENTAGE OF TIME		12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME		13.00
14.00	SUPPLIES	371,103	REQUISITIONS		14.00
15.00	DRUGS	136,370	REQUISITIONS		15.00
16.00	OTHER	76,899	ACCUMULATED COST		16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	1,258,913			17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	32,857	SQUARE FEET		18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	2,553	SALARY		20.00
21.00	ADMINISTRATIVE & GENERAL	178,572	ACCUMULATED COST		21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	424,801	SQUARE FEET		22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			23.00
24.00	CENTRAL SERVICE & SUPPLIES	0	REQUISITIONS		24.00
25.00	PHARMACY	0	REQUISITIONS		25.00
26.00	OTHER ALLOCATED COSTS	42,199	ACCUMULATED COST		26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	1,939,895			27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	29.00
30.00	ANCILLARY	0	CHARGES	0	30.00
30.01	PULMONARY FUNCTION TESTING	0	CHARGES	0	30.01
30.02	GASTRO INTESTINAL SERVICES	0	CHARGES	0	30.02
30.03	CARDIOLOGY	0	CHARGES	0	30.03
30.97	CARDIAC REHABILITATION	0	CHARGES	0	30.97
31.00	TOTAL COSTS (SUM OF LINES 27-30)	1,939,895			31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0013

Period:

Worksheet I-2

Component CCN: 14-2337

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 7:51 am

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	642,997	6,619	247,062	136,250	98,625	136,370	1.00
MAINTENANCE								
2.00	Hemodialysis	184,618	3,713	138,598	76,432	55,329	76,504	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	458,379	2,906	108,464	59,818	43,296	59,866	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						0	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	642,997	6,619	247,062	136,250	98,625	136,370	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	371,103	0	1,639,026	300,869	1,939,895		1.00
MAINTENANCE								
2.00	Hemodialysis	208,189	0	743,383	136,460	879,843		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	162,914	0	895,643	164,409	1,060,052		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	0	0		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	371,103	0	1,639,026	300,869	1,939,895		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					1,939,895		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0013

Period:

Worksheet I-3

Component CCN: 14-2337

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 7:51 am

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis	
		Building (Square Feet)	Equipment (%) of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00
1.00	Total Renal Department Costs	642,997	6,619	247,062	136,250	98,625	1.00
MAINTENANCE							
2.00	Hemodialysis	2,303	561.00	3,629.00	3,832.00	216,832	2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.01
TRAINING							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCPD	0	0.00	0.00	0.00	0	7.00
HOME							
8.00	Hemodialysis	5,718	439.00	2,840.00	2,999.00	169,678	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCPD	0	0.00	0.00	0.00	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0.00	0.00	0.00	0	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	8,021	1,000.00	6,469.00	6,831.00	386,510	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	80.164194	6.619000	38.191683	19.945835	0.255168	18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	136,370	371,103	0	1,639,026	300,869	1.00
MAINTENANCE							
2.00	Hemodialysis	76,503	208,189	0			2.00
2.01	AKI-Hemodialysis	0	0	0			2.01
3.00	Intermittent Peritoneal	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0			3.01
TRAINING							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCPD	0	0	0			7.00
HOME							
8.00	Hemodialysis	59,866	162,914	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCPD	0	0	0			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	ESAs						14.00
15.00							15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	136,369	371,103	0		1,639,026	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	1.000007	1.000000	0.000000		0.183566	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-0013

Period:

Worksheet I-4

Component CCN: 14-2337

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/24/2022 7:51 am

		Rate 0		Renal Dialysis		07/27/2022 7:01 am	
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	0	879,843	0.00	976	0	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	33	0	0.00	29	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - CAPD	0	0	0.00	0	0	5.00
6.00	Training - CCPD	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	393	1,060,052	2,697.33	349	941,368	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - CAPD	75	0	0.00	67	0	9.00
10.00	Home Program - CCPD	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	426	1,939,895		1,354	941,368	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	651					12.00
ADDITIONAL RENAL FACILITY NUMBERS							
20.00	PROCTOR HOSPITAL	142338					20.00
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)				
		6.00	7.00				
1.00	Maintenance - Hemodialysis	245,798	251.84				
2.00	Maintenance - Peritoneal Dialysis	0	0.00				
3.00	Training - Hemodialysis	10,215	352.24				
4.00	Training - Peritoneal Dialysis	0	0.00				
5.00	Training - CAPD	0	0.00				
6.00	Training - CCPD	0	0.00				
7.00	Home Program - Hemodialysis	102,691	294.24				
8.00	Home Program - Peritoneal Dialysis	0	0.00				
		6.00	7.00				
9.00	Home Program - CAPD	48,988	731.16				
10.00	Home Program - CCPD	0	0.00				
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	407,692					
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)						
ADDITIONAL RENAL FACILITY NUMBERS							
20.00	PROCTOR HOSPITAL						

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet I-5 Date/Time Prepared: 5/24/2022 7:51 am
		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	941,368		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	407,692	407,692	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	407,692	407,692	2.03
2.04	Outlier payments	3,890		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	49,214	49,214	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	49,214	49,214	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	49,214	8.00
9.00	Program payment (see instructions)	0	326,154	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	1,939,895		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	1,939,895		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0013	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/24/2022 7:51 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		714,948	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,136	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)		29.52	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)		3.24	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		7.54	8.00
9.00	Sum of lines 7 and 8		10.78	9.00
10.00	Allowable disproportionate share percentage (see instructions)		2.20	10.00
11.00	Disproportionate share adjustment (see instructions)		15,729	11.00
12.00	Total prospective capital payments (see instructions)		731,813	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