

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: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 7/5/2022 10:52 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION 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 SSM HEALTH ST. MARYS HOSPITAL (14-0034) 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	Eileen Lamm	Y	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	Eileen Lamm		2
3	Signatory Title	REGIONAL VP-FINANCE		3
4	Date	(Dated when report is electronica		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	-535,876	38,353	0	0	1.00
2.00 Subprovider - IPF	0	21,590	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
12.30 OOT I	0		0		0	12.30
200.00 Total	0	-514,286	38,353	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: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/5/2022 10:52 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 400 NORTH PLEASANT AVENUE			PO Box:				1.00			
2.00	City: CENTRALIA			State: IL		Zip Code: 62801-		County: MARION			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			SSM HEALTH ST. MARYS HOSPITAL	140034	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF			SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	N	P	P
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTG										
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										
17.30	Hospital-Based (OOT) I			ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N	O	N
18.00	Renal Dialysis										
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)						1				
							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.					Y	N				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		
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		
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				

Worksheet S-2
Part I
Date/Time Prepared:
7/5/2022 10:52 am

MCRIF32 - 17.6.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/5/2022 10:52 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)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
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
62.00	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
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/5/2022 10:52 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 7/5/2022 10:52 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)			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

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	84,908	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	269020	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/5/2022 10:52 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: SSM HEALTH		Contractor's Name: A		Contractor's Number: 05301				141.00		
142.00	Street: 10101 WOODFIELD LANE		PO Box:						142.00		
143.00	City: ST. LOUIS		State: MO		Zip Code: 63132				143.00		
								1.00			
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00	
								1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00		
								1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								Y	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00	
				Part A	Part B	Title V	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			155.00	
156.00	Subprovider - IPF			N	N	N	N			156.00	
157.00	Subprovider - IRF			N	N	N	N			157.00	
158.00	SUBPROVIDER									158.00	
159.00	SNF			N	N	N	N			159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00	
161.00	CMHC				N	N	N			161.00	
161.01					N	N	N			161.01	
161.30	OOT				N	N	N			161.30	
								1.00			
Multicampus											
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00	
		Name	County	State	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			166.00	
								1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act											
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00	
						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)									170.00	
						1.00	2.00				
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 7/5/2022 10:52 am	
		Y/N	Date				
		1.00	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	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
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	Legal Oper.				
		1.00	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	Date	Y/N	Date		
		1.00	2.00	3.00	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			16.00
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	04/20/2021	Y	04/20/2021		17.00
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			18.00
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			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/5/2022 10:52 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	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.	Y		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.	JENNIFER	COHEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3939	JENNIFER.COHEN@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/5/2022 10:52 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/5/2022 10:52 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	90	32,850	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)		90	32,850	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	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)		100	36,500	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.30 CMHC - OOT	99.30				0	25.30
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)		124				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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/5/2022 10:52 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)	6,858	243	10,140			1.00
2.00	HMO and other (see instructions)	1,417	1,873				2.00
3.00	HMO IPF Subprovider	32	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)	6,858	243	10,140			7.00
8.00	INTENSIVE CARE UNIT	1,362	128	1,504			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		49	249			13.00
14.00	Total (see instructions)	8,220	420	11,893	0.00	507.23	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	291	308	5,360	0.00	37.58	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
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	544.81	27.00
28.00	Observation Bed Days		29	1,123			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			85			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	61	71			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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/5/2022 10:52 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	1,606	103	3,169	1.00
2.00 HMO and other (see instructions)			288	218		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	1,606	103	3,169	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	31	63	906	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.30 CMHC - OOT	0.00					25.30
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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/5/2022 10:52 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	32,339,221	0	32,339,221	1,055,043.27	30.65
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		193,890	0	193,890	1,271.00	152.55
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,555,585	-36,747	2,518,838	87,665.61	28.73
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		575,525	0	575,525	8,428.38	68.28
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		110,645	0	110,645	462.50	239.23
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		4,778,200	0	4,778,200	108,104.83	44.20
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)		12,999,610	0	12,999,610		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,179,599	0	1,179,599		
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		17,102	0	17,102		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,803,247	0	1,803,247		
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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/5/2022 10:52 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	234,449	0	234,449	1,590.77	147.38	26.00
27.00	Administrative & General	5.00	3,768,246	-574,973	3,193,273	86,538.20	36.90	27.00
28.00	Administrative & General under contract (see inst.)		448,368	0	448,368	2,227.45	201.29	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	745,939	267	746,206	31,453.24	23.72	30.00
31.00	Laundry & Linen Service	8.00	87,838	0	87,838	5,602.86	15.68	31.00
32.00	Housekeeping	9.00	998,952	1,572	1,000,524	65,643.79	15.24	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	419,437	-294,319	125,118	11,199.37	11.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	294,319	294,319	14,679.70	20.05	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	520,963	5,000	525,963	11,340.46	46.38	38.00
39.00	Central Services and Supply	14.00	276,517	0	276,517	13,613.36	20.31	39.00
40.00	Pharmacy	15.00	1,181,847	738	1,182,585	31,901.69	37.07	40.00
41.00	Medical Records & Medical Records Library	16.00	167,555	0	167,555	10,040.33	16.69	41.00
42.00	Social Service	17.00	500,641	288	500,929	15,547.11	32.22	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
7/5/2022 10:52 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)	32,787,589	0	32,787,589	1,057,270.72	31.01	1.00
2.00	Excluded area salaries (see instructions)	2,555,585	-36,747	2,518,838	87,665.61	28.73	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,232,004	36,747	30,268,751	969,605.11	31.22	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,464,370	0	5,464,370	116,995.71	46.71	4.00
5.00	Subtotal wage-related costs (see inst.)	14,819,959	0	14,819,959	0.00	48.96	5.00
6.00	Total (sum of lines 3 thru 5)	50,516,333	36,747	50,553,080	1,086,600.82	46.52	6.00
7.00	Total overhead cost (see instructions)	9,350,752	-567,108	8,783,644	301,378.33	29.14	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 7/5/2022 10:52 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		986,175	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		1,078,164	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)		7,972,341	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	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		225,250	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		32,917	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		5,916	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		5,969	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		446,927	14.00
15.00	'Workers' Compensation Insurance		902,016	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,346,031	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		157,562	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		37,042	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		14,196,310	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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
7/5/2022 10:52 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	575,525	14,196,312	1.00
2.00	Hospital	575,525	12,999,610	2.00
3.00	SUBPROVIDER - IPF	0	1,000,739	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	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			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
16.30	Hospital-Based-CMHC 30	0	0	16.30
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	195,963	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 7/5/2022 10:52 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)			0.256941 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	12,449,173		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,462,202		5.00
6.00	Medicaid charges	90,360,871		6.00
7.00	Medicaid cost (line 1 times line 6)	23,217,413		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)	8,306,038		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)	8,306,038		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)	2,913,459	785,271	3,698,730 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	748,587	785,271	1,533,858 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)	748,587	785,271	1,533,858 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)	3,563,204		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	693,548		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,066,995		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,496,209		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,014,825		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,548,683		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,854,721		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A

Date/Time Prepared:
7/5/2022 10:52 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		5,756,014	5,756,014	0	5,756,014	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,888,091	2,888,091	0	2,888,091	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	234,449	11,445,619	11,680,068	-832	11,679,236	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,768,246	21,312,807	25,081,053	-982,772	24,098,281	5.00
7.00	00700	OPERATION OF PLANT	745,939	3,279,237	4,025,176	179,632	4,204,808	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,838	92,282	180,120	-1,146	178,974	8.00
9.00	00900	HOUSEKEEPING	998,952	396,275	1,395,227	-21,743	1,373,484	9.00
10.00	01000	DIETARY	419,437	662,570	1,082,007	-800,647	281,360	10.00
11.00	01100	CAFETERIA	0	0	0	800,492	800,492	11.00
13.00	01300	NURSING ADMINISTRATION	520,963	293,240	814,203	-68,538	745,665	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	276,517	194,778	471,295	-26,953	444,342	14.00
15.00	01500	PHARMACY	1,181,847	3,975,448	5,157,295	-3,751,363	1,405,932	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	167,555	115,115	282,670	-27	282,643	16.00
17.00	01700	SOCIAL SERVICE	500,641	154,266	654,907	283	655,190	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,399,388	1,694,733	7,094,121	148,250	7,242,371	30.00
31.00	03100	INTENSIVE CARE UNIT	1,673,527	1,022,012	2,695,539	-460,786	2,234,753	31.00
40.00	04000	SUBPROVIDER - IPF	2,279,684	308,469	2,588,153	68,935	2,657,088	40.00
43.00	04300	NURSERY	0	0	0	119,188	119,188	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,025,774	4,073,752	6,099,526	-3,070,618	3,028,908	50.00
51.00	05100	RECOVERY ROOM	175,828	23,580	199,408	4,888	204,296	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,498	127,720	840,218	-268,125	572,093	52.00
53.00	05300	ANESTHESIOLOGY	11,820	3,163,302	3,175,122	-127,637	3,047,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,315,128	302,468	1,617,596	-68,813	1,548,783	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	507,967	796,933	1,304,900	-3,550	1,301,350	55.00
56.00	05600	RADIOISOTOPE	82,469	307,511	389,980	-3,456	386,524	56.00
57.00	05700	CT SCAN	268,918	109,577	378,495	-50,036	328,459	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	101,770	40,587	142,357	-8,800	133,557	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,332	12,698	18,030	-11,370	6,660	59.00
60.00	06000	LABORATORY	1,543,067	2,745,389	4,288,456	-1,044,724	3,243,732	60.00
64.00	06400	INTRAVENOUS THERAPY	250,960	70,199	321,159	-18,855	302,304	64.00
65.00	06500	RESPIRATORY THERAPY	981,551	448,198	1,429,749	-88,735	1,341,014	65.00
66.00	06600	PHYSICAL THERAPY	1,174,620	228,738	1,403,358	95,946	1,499,304	66.00
66.01	03340	CLINICAL NUTRITION	109,575	8,379	117,954	0	117,954	66.01
67.00	06700	OCCUPATIONAL THERAPY	136,084	11,465	147,549	11,867	159,416	67.00
68.00	06800	SPEECH PATHOLOGY	118,981	10,197	129,178	8,192	137,370	68.00
69.00	06900	ELECTROCARDIOLOGY	774,101	473,224	1,247,325	-5,867	1,241,458	69.00
69.01	03140	CARDIAC REHABILITATION	123,995	10,467	134,462	4,174	138,636	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	103,043	155,005	258,048	-5,784	252,264	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,214,388	5,214,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	919,525	919,525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,711,086	3,711,086	73.00
74.00	07400	RENAL DIALYSIS	0	32,574	32,574	0	32,574	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,429,369	379,001	1,808,370	-13,957	1,794,413	90.00
91.00	09100	EMERGENCY	1,855,487	2,181,121	4,036,608	-250,431	3,786,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	126,605	9,676	136,281	-136,281	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,189,925	69,312,717	101,502,642	-5,000	101,497,642	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,946	2,290	8,236	0	8,236	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,106	78,485	150,591	5,000	155,591	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	71,214	73,372	144,586	0	144,586	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	30	103,786	103,816	0	103,816	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	32,339,221	69,570,650	101,909,871	0	101,909,871	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0034

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

Worksheet A

Date/Time Prepared:
7/5/2022 10:52 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	95,250	5,851,264	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,393,871	-505,780	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,652,117	16,331,353	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,685,520	12,412,761	5.00
7.00	00700	OPERATION OF PLANT	-34,315	4,170,493	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,974	8.00
9.00	00900	HOUSEKEEPING	-46,828	1,326,656	9.00
10.00	01000	DIETARY	0	281,360	10.00
11.00	01100	CAFETERIA	-216,550	583,942	11.00
13.00	01300	NURSING ADMINISTRATION	-1,009	744,656	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-94	444,248	14.00
15.00	01500	PHARMACY	-44,567	1,361,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-499	282,144	16.00
17.00	01700	SOCIAL SERVICE	0	655,190	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,102,339	6,140,032	30.00
31.00	03100	INTENSIVE CARE UNIT	-8,494	2,226,259	31.00
40.00	04000	SUBPROVIDER - IPF	-44,312	2,612,776	40.00
43.00	04300	NURSERY	0	119,188	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-113,607	2,915,301	50.00
51.00	05100	RECOVERY ROOM	0	204,296	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	572,093	52.00
53.00	05300	ANESTHESIOLOGY	-2,941,610	105,875	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,420	1,545,363	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-514,172	787,178	55.00
56.00	05600	RADIOISOTOPE	0	386,524	56.00
57.00	05700	CT SCAN	-710	327,749	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	133,557	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,660	59.00
60.00	06000	LABORATORY	-466,943	2,776,789	60.00
64.00	06400	INTRAVENOUS THERAPY	0	302,304	64.00
65.00	06500	RESPIRATORY THERAPY	-43,789	1,297,225	65.00
66.00	06600	PHYSICAL THERAPY	-102,142	1,397,162	66.00
66.01	06340	CLINICAL NUTRITION	0	117,954	66.01
67.00	06700	OCCUPATIONAL THERAPY	-53,535	105,881	67.00
68.00	06800	SPEECH PATHOLOGY	-1,267	136,103	68.00
69.00	06900	ELECTROCARDIOLOGY	-278,766	962,692	69.00
69.01	063140	CARDIAC REHABILITATION	280	138,916	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-141,857	110,407	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-219,033	4,995,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	919,525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,711,086	73.00
74.00	07400	RENAL DIALYSIS	0	32,574	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-102,986	1,691,427	90.00
91.00	09100	EMERGENCY	-1,387,054	2,399,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT	0	0	99.30
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,201,642	83,296,000	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,236	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	155,591	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	144,586	194.00
194.01	07951	NON-REIMBURSABLE	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	103,816	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,201,642	83,708,229	200.00

RECLASSIFICATIONS

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUG, SUPPLY, IMPLANT, IV, AND BLOOD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,214,388		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	919,525		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,711,086		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
			0	9,844,999		
B - DIETARY						
1.00	CAFETERIA	11.00	294,319	506,173		1.00
			294,319	506,173		
C - IMPATIENT L&D						
1.00	ADULTS & PEDIATRICS	30.00	285,130	153,757		1.00
2.00	NURSERY	43.00	93,181	25,640		2.00
3.00		0.00	0	0		3.00
	TOTALS		378,311	179,397		
E - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	179,650		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
			0	179,650		
F - PUMP RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	4,930		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	12,022		2.00
3.00	SUBPROVIDER - IPF	40.00	0	7,731		3.00
4.00	NURSERY	43.00	0	367		4.00
			0	25,050		
H - REHAB ADMIN						
1.00	PHYSICAL THERAPY	66.00	108,463	6,946		1.00
2.00	OCCUPATIONAL THERAPY	67.00	9,790	2,482		2.00
3.00	SPEECH PATHOLOGY	68.00	8,352	248		3.00
			126,605	9,676		
I - NURSING BONUS						
1.00	OPERATION OF PLANT	7.00	267	0		1.00
2.00	HOUSEKEEPING	9.00	1,572	0		2.00
3.00	NURSING ADMINISTRATION	13.00	5,000	0		3.00
4.00	PHARMACY	15.00	738	0		4.00
5.00	SOCIAL SERVICE	17.00	288	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	201,004	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	70,828	0		7.00
8.00	SUBPROVIDER - IPF	40.00	85,859	0		8.00

RECLASSIFICATIONS

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Period:
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
9.00	OPERATING ROOM	50.00	85,418	0	9.00
10.00	RECOVERY ROOM	51.00	10,528	0	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	5,000	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	5,534	0	12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	7,500	0	13.00
14.00	CT SCAN	57.00	372	0	14.00
15.00	LABORATORY	60.00	249	0	15.00
16.00	INTRAVENOUS THERAPY	64.00	12,500	0	16.00
17.00	RESPIRATORY THERAPY	65.00	138	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	12,500	0	18.00
19.00	CARDIAC REHABILITATION	69.01	5,000	0	19.00
20.00	CLINIC	90.00	15,000	0	20.00
21.00	EMERGENCY	91.00	44,678	0	21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	5,000	0	22.00
	TOTALS		574,973	0	
500.00	Grand Total: Increases		1,374,208	10,744,945	500.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:
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	Decreases					7/5/2022 10:32 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - DRUG, SUPPLY, IMPLANT, IV, AND BLOOD					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	832	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	242,336	0	2.00
3.00	OPERATION OF PLANT	7.00	0	285	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,052	0	4.00
5.00	HOUSEKEEPING	9.00	0	23,146	0	5.00
6.00	DIETARY	10.00	0	155	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	73,538	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,903	0	8.00
9.00	PHARMACY	15.00	0	3,752,101	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	27	0	10.00
11.00	SOCIAL SERVICE	17.00	0	5	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	0	496,571	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	0	230,501	0	13.00
14.00	SUBPROVIDER - IPF	40.00	0	23,516	0	14.00
15.00	OPERATING ROOM	50.00	0	3,156,036	0	15.00
16.00	RECOVERY ROOM	51.00	0	5,640	0	16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	0	29,691	0	17.00
18.00	ANESTHESIOLOGY	53.00	0	127,637	0	18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	74,347	0	19.00
20.00	RADIOLOGY-THERAPEUTIC	55.00	0	11,050	0	20.00
21.00	RADIOISOTOPE	56.00	0	3,456	0	21.00
22.00	CT SCAN	57.00	0	50,408	0	22.00
23.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8,800	0	23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	11,370	0	24.00
25.00	LABORATORY	60.00	0	1,044,973	0	25.00
26.00	INTRAVENOUS THERAPY	64.00	0	31,355	0	26.00
27.00	RESPIRATORY THERAPY	65.00	0	88,873	0	27.00
28.00	PHYSICAL THERAPY	66.00	0	10,912	0	28.00
29.00	OCCUPATIONAL THERAPY	67.00	0	405	0	29.00
30.00	SPEECH PATHOLOGY	68.00	0	408	0	30.00
31.00	ELECTROCARDIOLOGY	69.00	0	18,367	0	31.00
32.00	CARDIAC REHABILITATION	69.01	0	826	0	32.00
33.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,784	0	33.00
34.00	CLINIC	90.00	0	23,584	0	34.00
35.00	EMERGENCY	91.00	0	295,109	0	35.00
			0	9,844,999		
	B - DIETARY					
1.00	DIETARY	10.00	294,319	506,173	0	1.00
			294,319	506,173		
	C - IMPATIENT L&D					
1.00	INTENSIVE CARE UNIT	31.00	186,406	126,729	0	1.00
2.00	SUBPROVIDER - IPF	40.00	1,001	138	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	190,904	52,530	0	3.00
	TOTALS		378,311	179,397		
	E - UTILITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	165,463	0	1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	94	0	2.00
3.00	HOUSEKEEPING	9.00	0	169	0	3.00
4.00	PHYSICAL THERAPY	66.00	0	8,551	0	4.00
5.00	CLINIC	90.00	0	5,373	0	5.00
			0	179,650		
	F - PUMP RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	25,050	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
			0	25,050		
	H - REHAB ADMIN					
1.00	OOT	99.30	126,605	9,676	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
			126,605	9,676		
	I - NURSING BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	574,973	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00

RECLASSIFICATIONS

Provider CCN: 14-0034

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

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
	TOTALS		574,973	0		
500.00	Grand Total: Decreases		1,374,208	10,744,945		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
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		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	1,165,038	0	0	0	0	1.00	
2.00	Land Improvements	4,746,201	0	0	0	2,528,709	2.00	
3.00	Buildings and Fixtures	54,064,908	3,321,084	0	3,321,084	68,515	3.00	
4.00	Building Improvements	41,534	0	0	0	0	4.00	
5.00	Fixed Equipment	30,420,038	7,997	0	7,997	76,400	5.00	
6.00	Movable Equipment	53,832,186	2,056,630	0	2,056,630	281,023	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	144,269,905	5,385,711	0	5,385,711	2,954,647	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	144,269,905	5,385,711	0	5,385,711	2,954,647	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,165,038	0				1.00	
2.00	Land Improvements	2,217,492	0				2.00	
3.00	Buildings and Fixtures	57,317,477	0				3.00	
4.00	Building Improvements	41,534	0				4.00	
5.00	Fixed Equipment	30,351,635	0				5.00	
6.00	Movable Equipment	55,607,793	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	146,700,969	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	146,700,969	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
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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	1,945,968	0	3,810,046	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,888,091	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,834,059	0	3,810,046	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,756,014				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,888,091				2.00
3.00	Total (sum of lines 1-2)	0	8,644,105				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
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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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	2,041,218	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,304,266	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,345,484	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,810,046	0	0	0	5,851,264	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-3,810,046	0	0	0	-505,780	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	5,345,484	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			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)	A	-20,510	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,029,901			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	-3,734,083			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-216,550	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-44,567	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-499	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-9,072	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-32,974	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
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	MISCELLANEOUS REVENUE	B	-6,659,365	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0034

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

Worksheet A-8

Date/Time Prepared:
7/5/2022 10:52 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 MISCELLANEOUS REVENUE	B	-34,315	OPERATION OF PLANT	7.00	0	34.00
34.01 MISCELLANEOUS REVENUE	B	-46,828	HOUSEKEEPING	9.00	0	34.01
34.02 MISCELLANEOUS REVENUE	B	-94	CENTRAL SERVICES & SUPPLY	14.00	0	34.02
34.03 MISCELLANEOUS REVENUE	B	-3,420	RADIOLOGY-DIAGNOSTIC	54.00	0	34.03
34.04 MISCELLANEOUS REVENUE	B	-710	CT SCAN	57.00	0	34.04
34.05 MISCELLANEOUS REVENUE	B	-100,424	LABORATORY	60.00	0	34.05
34.06 MISCELLANEOUS REVENUE	B	-6,500	RESPIRATORY THERAPY	65.00	0	34.06
34.07 MISCELLANEOUS REVENUE	B	-34,700	PHYSICAL THERAPY	66.00	0	34.07
34.08 MISCELLANEOUS REVENUE	B	280	CARDIAC REHABILITATION	69.01	0	34.08
34.09 MISCELLANEOUS REVENUE	B	-12,571	ELECTROENCEPHALOGRAPHY	70.00	0	34.09
34.10 MISCELLANEOUS REVENUE	B	-8,693	CLINIC	90.00	0	34.10
34.11 MARKETING	B	-1,765	ADMINISTRATIVE & GENERAL	5.00	0	34.11
34.12 MARKETING	B	-2,772	RADIOLOGY-THERAPEUTIC	55.00	0	34.12
34.13 MARKETING	B	-218	RESPIRATORY THERAPY	65.00	0	34.13
34.14 MARKETING	B	-1,267	SPEECH PATHOLOGY	68.00	0	34.14
34.15 MARKETING	B	-25,015	CLINIC	90.00	0	34.15
34.16 RECRUITMENT	B	-10,063	ADMINISTRATIVE & GENERAL	5.00	0	34.16
34.17 RECRUITMENT	A	-295	NURSING ADMINISTRATION	13.00	0	34.17
34.18 RECRUITMENT	A	-995	OPERATING ROOM	50.00	0	34.18
34.19 RECRUITMENT	A	-5,674	ELECTROCARDIOLOGY	69.00	0	34.19
45.00 LOBBYING	A	-3,961	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01 GIFT	A	-14,100	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02 GIFT	A	-17,426	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03 GIFT	A	-714	NURSING ADMINISTRATION	13.00	0	45.03
45.04 GIFT	A	-389	RADIOLOGY-THERAPEUTIC	55.00	0	45.04
45.05 GIFT	A	-16	PHYSICAL THERAPY	66.00	0	45.05
45.06 GIFT	A	-246	ELECTROCARDIOLOGY	69.00	0	45.06
45.07 GIFT	A	-269	CLINIC	90.00	0	45.07
45.08 WSI RENT	A	-67,426	PHYSICAL THERAPY	66.00	0	45.08
45.09 PHYSICAN PART A BENEFITS	A	-53,535	OCCUPATIONAL THERAPY	67.00	0	45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,201,642				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:
7/5/2022 10:52 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	104,322	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	449,149	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE - INTEREST	0	3,810,046	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,666,217	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,640,270	12,564,962	4.01
4.02	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-219,033	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,640,925	16,375,008	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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	6.00
7.00	G	SSM HEALTH	100.00	FRAN SISTERS	100.00	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:	CHURCH				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: 14-0034

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

Worksheet A-8-1

Date/Time Prepared:
7/5/2022 10:52 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	104,322	9		1.00
2.00	449,149	9		2.00
3.00	-3,810,046	11		3.00
4.00	4,666,217	0		4.00
4.01	-4,924,692	0		4.01
4.02	-219,033	0		4.02
5.00	-3,734,083			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00	SSM HOSPITALS		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: 14-0034

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

Worksheet A-8-2

Date/Time Prepared:
7/5/2022 10:52 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	5.00	ADMINISTRATIVE & GENERAL	155,013	9,423	145,590	211,500	1,055	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,102,339	1,102,339	0	197,500	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	8,494	8,494	0	211,500	0	3.00
4.00	40.00	SUBPROVIDER - IPF	44,312	44,312	0	181,300	0	4.00
5.00	50.00	OPERATING ROOM	138,200	89,900	48,300	246,400	216	5.00
6.00	53.00	ANESTHESIOLOGY	2,941,610	2,941,610	0	239,400	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	511,011	511,011	0	271,900	0	7.00
8.00	60.00	LABORATORY	379,534	361,939	17,595	260,300	104	8.00
9.00	65.00	RESPIRATORY THERAPY	41,443	32,943	8,500	211,500	43	9.00
10.00	69.00	ELECTROCARDIOLOGY	281,896	260,646	21,250	211,500	89	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	133,658	125,158	8,500	211,500	43	11.00
12.00	90.00	CLINIC	69,009	69,009	0	197,500	0	12.00
13.00	91.00	EMERGENCY	1,413,071	1,358,271	54,800	197,500	274	13.00
200.00			7,219,590	6,915,055	304,535		1,824	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	5.00	ADMINISTRATIVE & GENERAL	107,275	5,364	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	25,588	1,279	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	13,015	651	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	4,372	219	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	9,050	453	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	4,372	219	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	26,017	1,301	0	0	0	13.00
200.00			189,689	9,486	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	5.00	ADMINISTRATIVE & GENERAL	0	107,275	38,315	47,738	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,102,339	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	8,494	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	44,312	4.00
5.00	50.00	OPERATING ROOM	0	25,588	22,712	112,612	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,941,610	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	511,011	7.00
8.00	60.00	LABORATORY	0	13,015	4,580	366,519	8.00
9.00	65.00	RESPIRATORY THERAPY	0	4,372	4,128	37,071	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	9,050	12,200	272,846	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	4,372	4,128	129,286	11.00
12.00	90.00	CLINIC	0	0	0	69,009	12.00
13.00	91.00	EMERGENCY	0	26,017	28,783	1,387,054	13.00
200.00			0	189,689	114,846	7,029,901	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/5/2022 10:52 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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,851,264	5,851,264				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-505,780		-505,780			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,331,353	31,915	0	16,363,268		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,412,761	1,766,092	0	1,627,557	15,806,410	5.00
7.00	00700	OPERATION OF PLANT	4,170,493	442,027	0	380,329	4,992,849	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,974	121,390	0	44,770	345,134	8.00
9.00	00900	HOUSEKEEPING	1,326,656	77,095	0	509,950	1,913,701	9.00
10.00	01000	DIETARY	281,360	43,258	0	63,771	388,389	10.00
11.00	01100	CAFETERIA	583,942	110,906	0	150,009	844,857	11.00
13.00	01300	NURSING ADMINISTRATION	744,656	10,907	0	268,074	1,023,637	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	444,248	7,157	0	140,936	592,341	14.00
15.00	01500	PHARMACY	1,361,365	0	0	602,743	1,964,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282,144	65,916	0	85,400	433,460	16.00
17.00	01700	SOCIAL SERVICE	655,190	27,403	0	255,315	937,908	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,140,032	746,210	0	2,999,761	9,886,003	30.00
31.00	03100	INTENSIVE CARE UNIT	2,226,259	79,059	0	794,060	3,099,378	31.00
40.00	04000	SUBPROVIDER - IPF	2,612,776	97,668	0	1,205,167	3,915,611	40.00
43.00	04300	NURSERY	119,188	53,033	0	47,493	219,714	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,915,301	623,021	0	1,076,039	4,614,361	50.00
51.00	05100	RECOVERY ROOM	204,296	0	0	94,982	299,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	572,093	90,006	0	268,396	930,495	52.00
53.00	05300	ANESTHESIOLOGY	105,875	5,671	0	6,024	117,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,545,363	175,663	0	673,119	2,394,145	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	787,178	0	0	262,725	1,049,903	55.00
56.00	05600	RADIOISOTOPE	386,524	12,870	0	42,033	441,427	56.00
57.00	05700	CT SCAN	327,749	3,190	0	137,253	468,192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	133,557	5,562	0	51,870	190,989	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,660	33,974	0	2,718	43,352	59.00
60.00	06000	LABORATORY	2,776,789	81,049	0	786,602	3,644,440	60.00
64.00	06400	INTRAVENOUS THERAPY	302,304	14,465	0	134,281	451,050	64.00
65.00	06500	RESPIRATORY THERAPY	1,297,225	17,055	0	500,350	1,814,630	65.00
66.00	06600	PHYSICAL THERAPY	1,397,162	64,907	0	653,966	2,116,035	66.00
66.01	03340	CLINICAL NUTRITION	117,954	0	0	55,849	173,803	66.01
67.00	06700	OCCUPATIONAL THERAPY	105,881	0	0	74,349	180,230	67.00
68.00	06800	SPEECH PATHOLOGY	136,103	9,857	0	64,899	210,859	68.00
69.00	06900	ELECTROCARDIOLOGY	962,692	81,785	0	400,917	1,445,394	69.00
69.01	03140	CARDIAC REHABILITATION	138,916	0	0	65,747	204,663	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	110,407	30,061	0	52,519	192,987	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,995,355	0	0	0	4,995,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	919,525	0	0	0	919,525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,711,086	0	0	0	3,711,086	73.00
74.00	07400	RENAL DIALYSIS	32,574	0	0	0	32,574	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,691,427	150,496	0	736,170	2,578,093	90.00
91.00	09100	EMERGENCY	2,399,123	147,961	0	968,482	3,515,566	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,296,000	5,227,629	0	16,284,625	83,099,502	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,236	4,472	0	3,031	15,739	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	155,591	0	0	39,300	194,891	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	144,586	619,163	0	36,297	800,046	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	103,816	0	0	15	103,831	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	-505,780	0	-505,780	201.00
202.00		TOTAL (sum lines 118 through 201)	83,708,229	5,851,264	-505,780	16,363,268	83,708,229	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	15,806,410					5.00
7.00	00700	OPERATION OF PLANT	1,153,658	6,146,507				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,747	206,612	631,493			8.00
9.00	00900	HOUSEKEEPING	442,184	131,221	0	2,487,106		9.00
10.00	01000	DIETARY	89,742	73,627	0	31,525	583,283	10.00
11.00	01100	CAFETERIA	195,214	188,767	0	80,825	0	11.00
13.00	01300	NURSING ADMINISTRATION	236,524	18,563	0	7,948	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	136,867	12,182	0	5,216	0	14.00
15.00	01500	PHARMACY	453,831	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100,156	112,193	0	48,038	0	16.00
17.00	01700	SOCIAL SERVICE	216,715	46,641	0	19,970	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,284,292	1,270,089	371,144	543,816	342,809	30.00
31.00	03100	INTENSIVE CARE UNIT	716,148	134,562	55,049	57,616	50,847	31.00
40.00	04000	SUBPROVIDER - IPF	904,749	166,236	196,186	71,177	181,209	40.00
43.00	04300	NURSERY	50,768	90,265	9,114	38,649	8,418	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,066,203	1,060,415	0	454,039	0	50.00
51.00	05100	RECOVERY ROOM	69,152	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,002	153,195	0	65,594	0	52.00
53.00	05300	ANESTHESIOLOGY	27,166	9,653	0	4,133	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	553,196	298,988	0	128,018	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	242,593	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	101,997	21,905	0	9,379	0	56.00
57.00	05700	CT SCAN	108,181	5,430	0	2,325	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	44,130	9,467	0	4,054	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,017	57,825	0	24,759	0	59.00
60.00	06000	LABORATORY	842,092	137,950	0	59,066	0	60.00
64.00	06400	INTRAVENOUS THERAPY	104,221	24,620	0	10,541	0	64.00
65.00	06500	RESPIRATORY THERAPY	419,292	29,029	0	12,429	0	65.00
66.00	06600	PHYSICAL THERAPY	488,935	110,476	0	47,303	0	66.00
66.01	03340	CLINICAL NUTRITION	40,159	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	41,644	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,722	16,777	0	7,183	0	68.00
69.00	06900	ELECTROCARDIOLOGY	333,976	139,203	0	59,603	0	69.00
69.01	03140	CARDIAC REHABILITATION	47,290	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	44,592	51,166	0	21,908	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,154,237	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,467	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,491	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,527	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	595,699	256,153	0	109,677	0	90.00
91.00	09100	EMERGENCY	812,314	251,837	0	107,829	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,548,890	5,085,047	631,493	2,032,620	583,283	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,637	7,611	0	3,259	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,032	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	184,860	1,053,849	0	451,227	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	23,991	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,806,410	6,146,507	631,493	2,487,106	583,283	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	1,309,663					11.00
13.00	01300	NURSING ADMINISTRATION	25,840	1,312,512				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,585	69	760,260			14.00
15.00	01500	PHARMACY	58,099	0	5,529	2,481,567		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,232	0	4	0	702,083	16.00
17.00	01700	SOCIAL SERVICE	24,610	44,009	1	16,769	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	289,157	462,292	67,181	113,220	45,441	30.00
31.00	03100	INTENSIVE CARE UNIT	76,540	214,494	31,185	35,286	9,313	31.00
40.00	04000	SUBPROVIDER - IPF	116,168	200,803	3,182	3,644	15,548	40.00
43.00	04300	NURSERY	4,578	9,950	0	0	799	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	103,721	183,714	427,376	288,641	86,164	50.00
51.00	05100	RECOVERY ROOM	9,155	21,022	763	2,339	9,065	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,871	55,699	4,017	6,156	4,381	52.00
53.00	05300	ANESTHESIOLOGY	581	0	17,268	984,980	25,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,883	28,133	10,215	74,684	32,830	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	25,324	13,568	1,534	0	14,144	55.00
56.00	05600	RADIOISOTOPE	4,052	0	14,187	640	13,923	56.00
57.00	05700	CT SCAN	13,230	0	6,843	897,859	87,913	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,000	0	3,986	23,294	18,631	58.00
59.00	05900	CARDIAC CATHETERIZATION	262	9	1,538	0	0	59.00
60.00	06000	LABORATORY	75,822	0	141,380	13,740	106,345	60.00
64.00	06400	INTRAVENOUS THERAPY	12,944	27,506	4,242	11,401	3,907	64.00
65.00	06500	RESPIRATORY THERAPY	48,229	0	14,827	0	23,850	65.00
66.00	06600	PHYSICAL THERAPY	63,037	0	1,476	3,620	19,975	66.00
66.01	03340	CLINICAL NUTRITION	5,383	0	0	0	88	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,167	0	55	0	2,302	67.00
68.00	06800	SPEECH PATHOLOGY	6,256	0	55	0	1,174	68.00
69.00	06900	ELECTROCARDIOLOGY	38,645	20,482	2,493	3,176	29,090	69.00
69.01	03140	CARDIAC REHABILITATION	6,337	13,897	112	271	1,299	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,062	23	783	1,847	2,617	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	59,136	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	121	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	70,960	0	0	0	13,075	90.00
91.00	09100	EMERGENCY	93,353	0	0	0	61,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,302,083	1,295,670	760,232	2,481,567	702,083	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	292	0	0	0	0	190.00
191.00	19100	RESEARCH	0	16,842	28	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,788	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	3,499	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	1	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,309,663	1,312,512	760,260	2,481,567	702,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
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	1,306,623				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	767,933	16,443,377	0	16,443,377	30.00
31.00	03100	INTENSIVE CARE UNIT	113,903	4,594,321	0	4,594,321	31.00
40.00	04000	SUBPROVIDER - IPF	405,929	6,180,442	0	6,180,442	40.00
43.00	04300	NURSERY	18,858	451,113	0	451,113	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,284,634	0	8,284,634	50.00
51.00	05100	RECOVERY ROOM	0	410,774	0	410,774	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,460,410	0	1,460,410	52.00
53.00	05300	ANESTHESIOLOGY	0	1,186,420	0	1,186,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,585,092	0	3,585,092	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,347,066	0	1,347,066	55.00
56.00	05600	RADIOISOTOPE	0	607,510	0	607,510	56.00
57.00	05700	CT SCAN	0	1,589,973	0	1,589,973	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	299,551	0	299,551	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	137,762	0	137,762	59.00
60.00	06000	LABORATORY	0	5,020,835	0	5,020,835	60.00
64.00	06400	INTRAVENOUS THERAPY	0	650,432	0	650,432	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,362,286	0	2,362,286	65.00
66.00	06600	PHYSICAL THERAPY	0	2,850,857	0	2,850,857	66.00
66.01	03340	CLINICAL NUTRITION	0	219,433	0	219,433	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	231,398	0	231,398	67.00
68.00	06800	SPEECH PATHOLOGY	0	291,026	0	291,026	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,072,062	0	2,072,062	69.00
69.01	03140	CARDIAC REHABILITATION	0	273,869	0	273,869	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	320,985	0	320,985	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,159,575	0	6,159,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,136,794	0	1,136,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,627,713	0	4,627,713	73.00
74.00	07400	RENAL DIALYSIS	0	40,222	0	40,222	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	3,623,657	0	3,623,657	90.00
91.00	09100	EMERGENCY	0	4,841,997	0	4,841,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,306,623	81,301,586	0	81,301,586	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,538	0	30,538	190.00
191.00	19100	RESEARCH	0	16,870	0	16,870	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	243,711	0	243,711	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	2,493,481	0	2,493,481	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	127,823	0	127,823	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	-505,780	0	-505,780	201.00
202.00		TOTAL (sum lines 118 through 201)	1,306,623	83,708,229	0	83,708,229	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	31,915	0	31,915	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,147	1,766,092	0	1,774,239	5.00
7.00	00700	OPERATION OF PLANT	424	442,027	0	442,451	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,390	0	121,390	8.00
9.00	00900	HOUSEKEEPING	23,541	77,095	0	100,636	9.00
10.00	01000	DIETARY	0	43,258	0	43,258	10.00
11.00	01100	CAFETERIA	0	110,906	0	110,906	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,907	0	10,907	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,449	7,157	0	41,606	14.00
15.00	01500	PHARMACY	90,600	0	0	90,600	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,916	0	65,916	16.00
17.00	01700	SOCIAL SERVICE	0	27,403	0	27,403	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,295	746,210	0	748,505	30.00
31.00	03100	INTENSIVE CARE UNIT	871	79,059	0	79,930	31.00
40.00	04000	SUBPROVIDER - IPF	0	97,668	0	97,668	40.00
43.00	04300	NURSERY	0	53,033	0	53,033	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,291	623,021	0	657,312	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	90,006	0	90,006	52.00
53.00	05300	ANESTHESIOLOGY	0	5,671	0	5,671	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	175,663	0	175,663	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	12,870	0	12,870	56.00
57.00	05700	CT SCAN	0	3,190	0	3,190	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,562	0	5,562	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	33,974	0	33,974	59.00
60.00	06000	LABORATORY	106	81,049	0	81,155	60.00
64.00	06400	INTRAVENOUS THERAPY	0	14,465	0	14,465	64.00
65.00	06500	RESPIRATORY THERAPY	44,168	17,055	0	61,223	65.00
66.00	06600	PHYSICAL THERAPY	76,466	64,907	0	141,373	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,857	0	9,857	68.00
69.00	06900	ELECTROCARDIOLOGY	14,380	81,785	0	96,165	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	30,061	0	30,061	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	52,013	150,496	0	202,509	90.00
91.00	09100	EMERGENCY	0	147,961	0	147,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	381,751	5,227,629	0	5,609,380	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,472	0	4,472	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,975	0	0	48,975	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	14,472	619,163	0	633,635	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-505,780	-505,780	201.00
202.00		TOTAL (sum lines 118 through 201)	445,198	5,851,264	-505,780	5,790,682	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

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Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	1,777,413					5.00
7.00	00700	OPERATION OF PLANT	129,729	572,922				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,968	19,258	149,703			8.00
9.00	00900	HOUSEKEEPING	49,724	12,231	0	163,586		9.00
10.00	01000	DIETARY	10,092	6,863	0	2,074	62,411	10.00
11.00	01100	CAFETERIA	21,952	17,595	0	5,316	0	11.00
13.00	01300	NURSING ADMINISTRATION	26,597	1,730	0	523	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,391	1,136	0	343	0	14.00
15.00	01500	PHARMACY	51,033	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,263	10,458	0	3,160	0	16.00
17.00	01700	SOCIAL SERVICE	24,370	4,347	0	1,314	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	256,844	118,388	87,984	35,768	36,680	30.00
31.00	03100	INTENSIVE CARE UNIT	80,531	12,543	13,050	3,790	5,441	31.00
40.00	04000	SUBPROVIDER - IPF	101,739	15,495	46,508	4,682	19,389	40.00
43.00	04300	NURSERY	5,709	8,414	2,161	2,542	901	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	119,895	98,842	0	29,864	0	50.00
51.00	05100	RECOVERY ROOM	7,776	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,177	14,279	0	4,314	0	52.00
53.00	05300	ANESTHESIOLOGY	3,055	900	0	272	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,207	27,869	0	8,420	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27,280	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	11,470	2,042	0	617	0	56.00
57.00	05700	CT SCAN	12,165	506	0	153	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,962	882	0	267	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,126	5,390	0	1,628	0	59.00
60.00	06000	LABORATORY	94,693	12,858	0	3,885	0	60.00
64.00	06400	INTRAVENOUS THERAPY	11,720	2,295	0	693	0	64.00
65.00	06500	RESPIRATORY THERAPY	47,150	2,706	0	818	0	65.00
66.00	06600	PHYSICAL THERAPY	54,981	10,298	0	3,111	0	66.00
66.01	03340	CLINICAL NUTRITION	4,516	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,683	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,479	1,564	0	472	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,556	12,975	0	3,920	0	69.00
69.01	03140	CARDIAC REHABILITATION	5,318	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,014	4,769	0	1,441	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,794	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,892	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,425	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	846	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	66,987	23,876	0	7,214	0	90.00
91.00	09100	EMERGENCY	91,345	23,474	0	7,092	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,748,454	473,983	149,703	133,693	62,411	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	409	709	0	214	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,064	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	20,788	98,230	0	29,679	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	2,698	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,777,413	572,922	149,703	163,586	62,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	156,062					11.00
13.00	01300	NURSING ADMINISTRATION	3,079	43,359				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,619	2	60,372			14.00
15.00	01500	PHARMACY	6,923	0	439	150,170		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	981	0	0	0	91,945	16.00
17.00	01700	SOCIAL SERVICE	2,932	1,454	0	1,015	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,464	15,272	5,335	6,851	5,959	30.00
31.00	03100	INTENSIVE CARE UNIT	9,120	7,086	2,477	2,135	1,221	31.00
40.00	04000	SUBPROVIDER - IPF	13,842	6,634	253	221	2,039	40.00
43.00	04300	NURSERY	545	329	0	0	105	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,359	6,069	33,938	17,467	11,300	50.00
51.00	05100	RECOVERY ROOM	1,091	694	61	142	1,189	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,083	1,840	319	373	575	52.00
53.00	05300	ANESTHESIOLOGY	69	0	1,371	59,605	3,288	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,731	929	811	4,519	4,305	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,018	448	122	0	1,855	55.00
56.00	05600	RADIOISOTOPE	483	0	1,127	39	1,826	56.00
57.00	05700	CT SCAN	1,576	0	543	54,333	11,529	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	596	0	317	1,410	2,443	58.00
59.00	05900	CARDIAC CATHETERIZATION	31	0	122	0	0	59.00
60.00	06000	LABORATORY	9,035	0	11,227	831	13,820	60.00
64.00	06400	INTRAVENOUS THERAPY	1,542	909	337	690	512	64.00
65.00	06500	RESPIRATORY THERAPY	5,747	0	1,177	0	3,128	65.00
66.00	06600	PHYSICAL THERAPY	7,511	0	117	219	2,619	66.00
66.01	03340	CLINICAL NUTRITION	641	0	0	0	11	66.01
67.00	06700	OCCUPATIONAL THERAPY	854	0	4	0	302	67.00
68.00	06800	SPEECH PATHOLOGY	745	0	4	0	154	68.00
69.00	06900	ELECTROCARDIOLOGY	4,605	677	198	192	3,815	69.00
69.01	03140	CARDIAC REHABILITATION	755	459	9	16	170	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	603	1	62	112	343	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	630	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,755	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	16	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,455	0	0	0	1,715	90.00
91.00	09100	EMERGENCY	11,124	0	0	0	8,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	155,159	42,803	60,370	150,170	91,945	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35	0	0	0	0	190.00
191.00	19100	RESEARCH	0	556	2	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	451	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	417	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	156,062	43,359	60,372	150,170	91,945	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
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	63,333				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,222	1,395,123	0	1,395,123	30.00
31.00	03100	INTENSIVE CARE UNIT	5,521	224,394	0	224,394	31.00
40.00	04000	SUBPROVIDER - IPF	19,676	330,496	0	330,496	40.00
43.00	04300	NURSERY	914	74,746	0	74,746	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	989,145	0	989,145	50.00
51.00	05100	RECOVERY ROOM	0	11,138	0	11,138	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	139,489	0	139,489	52.00
53.00	05300	ANESTHESIOLOGY	0	74,243	0	74,243	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	293,767	0	293,767	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	33,235	0	33,235	55.00
56.00	05600	RADIOISOTOPE	0	30,556	0	30,556	56.00
57.00	05700	CT SCAN	0	84,263	0	84,263	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,540	0	16,540	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	42,276	0	42,276	59.00
60.00	06000	LABORATORY	0	229,038	0	229,038	60.00
64.00	06400	INTRAVENOUS THERAPY	0	33,425	0	33,425	64.00
65.00	06500	RESPIRATORY THERAPY	0	122,925	0	122,925	65.00
66.00	06600	PHYSICAL THERAPY	0	221,504	0	221,504	66.00
66.01	03340	CLINICAL NUTRITION	0	5,277	0	5,277	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	5,988	0	5,988	67.00
68.00	06800	SPEECH PATHOLOGY	0	18,402	0	18,402	68.00
69.00	06900	ELECTROCARDIOLOGY	0	160,885	0	160,885	69.00
69.01	03140	CARDIAC REHABILITATION	0	6,855	0	6,855	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,508	0	42,508	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	131,103	0	131,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,522	0	24,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	104,180	0	104,180	73.00
74.00	07400	RENAL DIALYSIS	0	862	0	862	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	312,192	0	312,192	90.00
91.00	09100	EMERGENCY	0	290,897	0	290,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,333	5,449,974	0	5,449,974	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,845	0	5,845	190.00
191.00	19100	RESEARCH	0	558	0	558	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	54,567	0	54,567	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	782,820	0	782,820	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	2,698	0	2,698	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	-505,780	0	-505,780	201.00
202.00		TOTAL (sum lines 118 through 201)	63,333	5,790,682	0	5,790,682	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	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	429,194				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		429,194			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	2,341	32,104,772		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	129,544	129,544	3,193,273	-15,806,410	5.00
7.00	00700	OPERATION OF PLANT	32,423	32,423	746,206	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	8,904	87,838	0	8.00
9.00	00900	HOUSEKEEPING	5,655	5,655	1,000,524	0	9.00
10.00	01000	DIETARY	3,173	3,173	125,118	0	10.00
11.00	01100	CAFETERIA	8,135	8,135	294,319	0	11.00
13.00	01300	NURSING ADMINISTRATION	800	800	525,963	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	525	276,517	0	14.00
15.00	01500	PHARMACY	0	0	1,182,585	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	4,835	167,555	0	16.00
17.00	01700	SOCIAL SERVICE	2,010	2,010	500,929	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,735	54,735	5,885,522	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	5,799	1,557,949	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	7,164	2,364,542	0	40.00
43.00	04300	NURSERY	3,890	3,890	93,181	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,699	45,699	2,111,192	0	50.00
51.00	05100	RECOVERY ROOM	0	0	186,356	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	6,602	526,594	0	52.00
53.00	05300	ANESTHESIOLOGY	416	416	11,820	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	12,885	1,320,662	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	515,467	0	55.00
56.00	05600	RADIOISOTOPE	944	944	82,469	0	56.00
57.00	05700	CT SCAN	234	234	269,290	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	408	101,770	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,492	2,492	5,332	0	59.00
60.00	06000	LABORATORY	5,945	5,945	1,543,316	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	1,061	263,460	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	1,251	981,689	0	65.00
66.00	06600	PHYSICAL THERAPY	4,761	4,761	1,283,083	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	109,575	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	145,874	0	67.00
68.00	06800	SPEECH PATHOLOGY	723	723	127,333	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	5,999	786,601	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	128,995	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	2,205	103,043	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,039	11,039	1,444,369	0	90.00
91.00	09100	EMERGENCY	10,853	10,853	1,900,165	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,450	383,450	31,950,476	-15,806,410	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	328	5,946	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	77,106	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	45,416	71,214	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	30	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,851,264	-505,780	16,363,268	15,806,410	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.633145	0.000000	0.509683	0.231062	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			31,915	1,777,413	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000994		0.025983	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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
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
7.00	00700	OPERATION OF PLANT	264,886				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,904	17,253			8.00
9.00	00900	HOUSEKEEPING	5,655	0	250,327		9.00
10.00	01000	DIETARY	3,173	0	3,173	17,253	10.00
11.00	01100	CAFETERIA	8,135	0	8,135	0	11.00
13.00	01300	NURSING ADMINISTRATION	800	0	800	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	525	0	525	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	0	4,835	0	16.00
17.00	01700	SOCIAL SERVICE	2,010	0	2,010	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,735	10,140	54,735	10,140	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	1,504	5,799	1,504	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	5,360	7,164	5,360	40.00
43.00	04300	NURSERY	3,890	249	3,890	249	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	45,699	0	45,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	0	6,602	0	52.00
53.00	05300	ANESTHESIOLOGY	416	0	416	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,885	0	12,885	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	944	0	944	0	56.00
57.00	05700	CT SCAN	234	0	234	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408	0	408	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,492	0	2,492	0	59.00
60.00	06000	LABORATORY	5,945	0	5,945	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	0	1,061	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	0	1,251	0	65.00
66.00	06600	PHYSICAL THERAPY	4,761	0	4,761	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	723	0	723	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	0	5,999	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	0	2,205	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	11,039	0	11,039	0	90.00
91.00	09100	EMERGENCY	10,853	0	10,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219,142	17,253	204,583	17,253	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	0	328	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	45,416	0	45,416	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,146,507	631,493	2,487,106	583,283	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.204348	36.601924	9.935428	33.807628	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	572,922	149,703	163,586	62,411	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.162900	8.676926	0.653489	3.617400	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	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
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	286,637					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15	5,619,381				14.00
15.00	01500	PHARMACY	0	40,867	100,779			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27	0	316,420,839		16.00
17.00	01700	SOCIAL SERVICE	9,611	5	681	0	17,253	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	100,959	496,566	4,598	20,478,131	10,140	30.00
31.00	03100	INTENSIVE CARE UNIT	46,843	230,502	1,433	4,197,005	1,504	31.00
40.00	04000	SUBPROVIDER - IPF	43,853	23,516	148	7,006,653	5,360	40.00
43.00	04300	NURSERY	2,173	0	0	360,050	249	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,121	3,158,893	11,722	38,829,928	0	50.00
51.00	05100	RECOVERY ROOM	4,591	5,640	95	4,085,220	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,164	29,691	250	1,974,489	0	52.00
53.00	05300	ANESTHESIOLOGY	0	127,636	40,001	11,297,576	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,144	75,506	3,033	14,794,976	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,963	11,340	0	6,373,957	0	55.00
56.00	05600	RADIOISOTOPE	0	104,859	26	6,274,387	0	56.00
57.00	05700	CT SCAN	0	50,583	36,463	39,618,493	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,461	946	8,396,273	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2	11,370	0	0	0	59.00
60.00	06000	LABORATORY	0	1,044,999	558	47,949,910	0	60.00
64.00	06400	INTRAVENOUS THERAPY	6,007	31,355	463	1,760,480	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	109,593	0	10,748,182	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,912	147	9,001,661	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	39,465	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	404	0	1,037,445	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	408	0	529,145	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,473	18,429	129	13,109,455	0	69.00
69.01	03140	CARDIAC REHABILITATION	3,035	826	11	585,276	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5	5,784	75	1,179,377	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,498,815	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,164,223	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,649,847	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	54,385	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,892,216	0	90.00
91.00	09100	EMERGENCY	0	0	0	27,533,819	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0	0	0	99.30
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	282,959	5,619,172	100,779	316,420,839	17,253	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	3,678	207	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
194.00	07950	NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	NON-REIMBURSABLE	0	0	0	0	0	194.01
194.02	07952	NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	CONTRACT PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,312,512	760,260	2,481,567	702,083	1,306,623	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.579004	0.135292	24.623850	0.002219	75.733090	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,359	60,372	150,170	91,945	63,333	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.151268	0.010744	1.490092	0.000291	3.670840	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0034

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

Worksheet B-1

Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	13.00	14.00	15.00	16.00	17.00	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/5/2022 10:52 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,443,377		16,443,377	0	16,443,377	30.00
31.00	03100	INTENSIVE CARE UNIT	4,594,321		4,594,321	0	4,594,321	31.00
40.00	04000	SUBPROVIDER - IPF	6,180,442		6,180,442	0	6,180,442	40.00
43.00	04300	NURSERY	451,113		451,113	0	451,113	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,284,634		8,284,634	22,712	8,307,346	50.00
51.00	05100	RECOVERY ROOM	410,774		410,774	0	410,774	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,460,410		1,460,410	0	1,460,410	52.00
53.00	05300	ANESTHESIOLOGY	1,186,420		1,186,420	0	1,186,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,585,092		3,585,092	0	3,585,092	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,347,066		1,347,066	0	1,347,066	55.00
56.00	05600	RADIOISOTOPE	607,510		607,510	0	607,510	56.00
57.00	05700	CT SCAN	1,589,973		1,589,973	0	1,589,973	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	299,551		299,551	0	299,551	58.00
59.00	05900	CARDIAC CATHETERIZATION	137,762		137,762	0	137,762	59.00
60.00	06000	LABORATORY	5,020,835		5,020,835	4,580	5,025,415	60.00
64.00	06400	INTRAVENOUS THERAPY	650,432		650,432	0	650,432	64.00
65.00	06500	RESPIRATORY THERAPY	2,362,286	0	2,362,286	4,128	2,366,414	65.00
66.00	06600	PHYSICAL THERAPY	2,850,857	0	2,850,857	0	2,850,857	66.00
66.01	03340	CLINICAL NUTRITION	219,433	0	219,433	0	219,433	66.01
67.00	06700	OCCUPATIONAL THERAPY	231,398	0	231,398	0	231,398	67.00
68.00	06800	SPEECH PATHOLOGY	291,026	0	291,026	0	291,026	68.00
69.00	06900	ELECTROCARDIOLOGY	2,072,062		2,072,062	12,200	2,084,262	69.00
69.01	03140	CARDIAC REHABILITATION	273,869		273,869	0	273,869	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	320,985		320,985	4,128	325,113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,159,575		6,159,575	0	6,159,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,136,794		1,136,794	0	1,136,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,627,713		4,627,713	0	4,627,713	73.00
74.00	07400	RENAL DIALYSIS	40,222		40,222	0	40,222	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,623,657		3,623,657	0	3,623,657	90.00
91.00	09100	EMERGENCY	4,841,997		4,841,997	28,783	4,870,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,639,524		1,639,524		1,639,524	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0		0		0	99.30
200.00		Subtotal (see instructions)	82,941,110	0	82,941,110	76,531	83,017,641	200.00
201.00		Less Observation Beds	1,639,524		1,639,524		1,639,524	201.00
202.00		Total (see instructions)	81,301,586	0	81,301,586	76,531	81,378,117	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/5/2022 10:52 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	19,098,208		19,098,208			30.00
31.00	03100	INTENSIVE CARE UNIT	4,197,005		4,197,005			31.00
40.00	04000	SUBPROVIDER - IPF	7,006,653		7,006,653			40.00
43.00	04300	NURSERY	360,050		360,050			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,738,196	29,091,732	38,829,928	0.213357	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,227,180	2,858,040	4,085,220	0.100551	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,475,782	498,707	1,974,489	0.739639	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,704,392	7,593,184	11,297,576	0.105015	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,212,485	12,582,491	14,794,976	0.242318	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,955	6,362,002	6,373,957	0.211339	0.000000	55.00
56.00	05600	RADIOISOTOPE	330,903	5,943,484	6,274,387	0.096824	0.000000	56.00
57.00	05700	CT SCAN	8,056,419	31,562,074	39,618,493	0.040132	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	983,084	7,413,189	8,396,273	0.035677	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	16,241,357	31,708,553	47,949,910	0.104710	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	7,195	1,753,285	1,760,480	0.369463	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,159,726	4,588,456	10,748,182	0.219785	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,402,795	7,598,866	9,001,661	0.316703	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	39,465	39,465	5.560193	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	339,635	697,810	1,037,445	0.223046	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	170,955	358,190	529,145	0.549993	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,948,800	9,160,655	13,109,455	0.158059	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	585,276	585,276	0.467931	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	147,220	1,032,157	1,179,377	0.272165	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,550,561	948,254	4,498,815	1.369155	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,226,461	937,762	2,164,223	0.525267	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,510,141	14,139,706	26,649,847	0.173649	0.000000	73.00
74.00	07400	RENAL DIALYSIS	46,585	7,800	54,385	0.739579	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	584,879	5,307,337	5,892,216	0.614991	0.000000	90.00
91.00	09100	EMERGENCY	6,673,895	20,859,924	27,533,819	0.175856	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	270,188	1,109,735	1,379,923	1.188127	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0			99.30
200.00		Subtotal (see instructions)	111,682,705	204,738,134	316,420,839			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	111,682,705	204,738,134	316,420,839			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/5/2022 10:52 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.213942		50.00
51.00	05100	RECOVERY ROOM	0.100551		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.739639		52.00
53.00	05300	ANESTHESIOLOGY	0.105015		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242318		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.211339		55.00
56.00	05600	RADIOISOTOPE	0.096824		56.00
57.00	05700	CT SCAN	0.040132		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.035677		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.104806		60.00
64.00	06400	INTRAVENOUS THERAPY	0.369463		64.00
65.00	06500	RESPIRATORY THERAPY	0.220169		65.00
66.00	06600	PHYSICAL THERAPY	0.316703		66.00
66.01	03340	CLINICAL NUTRITION	5.560193		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.223046		67.00
68.00	06800	SPEECH PATHOLOGY	0.549993		68.00
69.00	06900	ELECTROCARDIOLOGY	0.158989		69.00
69.01	03140	CARDIAC REHABILITATION	0.467931		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275665		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.369155		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525267		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173649		73.00
74.00	07400	RENAL DIALYSIS	0.739579		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.614991		90.00
91.00	09100	EMERGENCY	0.176902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.188127		92.00
OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT			99.30
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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/5/2022 10:52 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total 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	16,443,377		16,443,377	0	16,443,377	30.00
31.00	03100	INTENSIVE CARE UNIT	4,594,321		4,594,321	0	4,594,321	31.00
40.00	04000	SUBPROVIDER - IPF	6,180,442		6,180,442	0	6,180,442	40.00
43.00	04300	NURSERY	451,113		451,113	0	451,113	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,284,634		8,284,634	22,712	8,307,346	50.00
51.00	05100	RECOVERY ROOM	410,774		410,774	0	410,774	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,460,410		1,460,410	0	1,460,410	52.00
53.00	05300	ANESTHESIOLOGY	1,186,420		1,186,420	0	1,186,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,585,092		3,585,092	0	3,585,092	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,347,066		1,347,066	0	1,347,066	55.00
56.00	05600	RADIOISOTOPE	607,510		607,510	0	607,510	56.00
57.00	05700	CT SCAN	1,589,973		1,589,973	0	1,589,973	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	299,551		299,551	0	299,551	58.00
59.00	05900	CARDIAC CATHETERIZATION	137,762		137,762	0	137,762	59.00
60.00	06000	LABORATORY	5,020,835		5,020,835	4,580	5,025,415	60.00
64.00	06400	INTRAVENOUS THERAPY	650,432		650,432	0	650,432	64.00
65.00	06500	RESPIRATORY THERAPY	2,362,286	0	2,362,286	4,128	2,366,414	65.00
66.00	06600	PHYSICAL THERAPY	2,850,857	0	2,850,857	0	2,850,857	66.00
66.01	03340	CLINICAL NUTRITION	219,433	0	219,433	0	219,433	66.01
67.00	06700	OCCUPATIONAL THERAPY	231,398	0	231,398	0	231,398	67.00
68.00	06800	SPEECH PATHOLOGY	291,026	0	291,026	0	291,026	68.00
69.00	06900	ELECTROCARDIOLOGY	2,072,062		2,072,062	12,200	2,084,262	69.00
69.01	03140	CARDIAC REHABILITATION	273,869		273,869	0	273,869	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	320,985		320,985	4,128	325,113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,159,575		6,159,575	0	6,159,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,136,794		1,136,794	0	1,136,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,627,713		4,627,713	0	4,627,713	73.00
74.00	07400	RENAL DIALYSIS	40,222		40,222	0	40,222	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,623,657		3,623,657	0	3,623,657	90.00
91.00	09100	EMERGENCY	4,841,997		4,841,997	28,783	4,870,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,639,524		1,639,524		1,639,524	92.00
OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0		0		0	99.30
200.00		Subtotal (see instructions)	82,941,110	0	82,941,110	76,531	83,017,641	200.00
201.00		Less Observation Beds	1,639,524		1,639,524		1,639,524	201.00
202.00		Total (see instructions)	81,301,586	0	81,301,586	76,531	81,378,117	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/5/2022 10:52 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	19,098,208		19,098,208		30.00
31.00	03100	INTENSIVE CARE UNIT	4,197,005		4,197,005		31.00
40.00	04000	SUBPROVIDER - IPF	7,006,653		7,006,653		40.00
43.00	04300	NURSERY	360,050		360,050		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,738,196	29,091,732	38,829,928	0.213357	0.000000
51.00	05100	RECOVERY ROOM	1,227,180	2,858,040	4,085,220	0.100551	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,475,782	498,707	1,974,489	0.739639	0.000000
53.00	05300	ANESTHESIOLOGY	3,704,392	7,593,184	11,297,576	0.105015	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,212,485	12,582,491	14,794,976	0.242318	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	11,955	6,362,002	6,373,957	0.211339	0.000000
56.00	05600	RADIOISOTOPE	330,903	5,943,484	6,274,387	0.096824	0.000000
57.00	05700	CT SCAN	8,056,419	31,562,074	39,618,493	0.040132	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	983,084	7,413,189	8,396,273	0.035677	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	16,241,357	31,708,553	47,949,910	0.104710	0.000000
64.00	06400	INTRAVENOUS THERAPY	7,195	1,753,285	1,760,480	0.369463	0.000000
65.00	06500	RESPIRATORY THERAPY	6,159,726	4,588,456	10,748,182	0.219785	0.000000
66.00	06600	PHYSICAL THERAPY	1,402,795	7,598,866	9,001,661	0.316703	0.000000
66.01	03340	CLINICAL NUTRITION	0	39,465	39,465	5.560193	0.000000
67.00	06700	OCCUPATIONAL THERAPY	339,635	697,810	1,037,445	0.223046	0.000000
68.00	06800	SPEECH PATHOLOGY	170,955	358,190	529,145	0.549993	0.000000
69.00	06900	ELECTROCARDIOLOGY	3,948,800	9,160,655	13,109,455	0.158059	0.000000
69.01	03140	CARDIAC REHABILITATION	0	585,276	585,276	0.467931	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	147,220	1,032,157	1,179,377	0.272165	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,550,561	948,254	4,498,815	1.369155	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,226,461	937,762	2,164,223	0.525267	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	12,510,141	14,139,706	26,649,847	0.173649	0.000000
74.00	07400	RENAL DIALYSIS	46,585	7,800	54,385	0.739579	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	584,879	5,307,337	5,892,216	0.614991	0.000000
91.00	09100	EMERGENCY	6,673,895	20,859,924	27,533,819	0.175856	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	270,188	1,109,735	1,379,923	1.188127	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0		99.30
200.00		Subtotal (see instructions)	111,682,705	204,738,134	316,420,839		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	111,682,705	204,738,134	316,420,839		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/5/2022 10:52 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.213942		50.00
51.00	05100	RECOVERY ROOM	0.100551		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.739639		52.00
53.00	05300	ANESTHESIOLOGY	0.105015		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242318		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.211339		55.00
56.00	05600	RADIOISOTOPE	0.096824		56.00
57.00	05700	CT SCAN	0.040132		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.035677		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.104806		60.00
64.00	06400	INTRAVENOUS THERAPY	0.369463		64.00
65.00	06500	RESPIRATORY THERAPY	0.220169		65.00
66.00	06600	PHYSICAL THERAPY	0.316703		66.00
66.01	03340	CLINICAL NUTRITION	5.560193		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.223046		67.00
68.00	06800	SPEECH PATHOLOGY	0.549993		68.00
69.00	06900	ELECTROCARDIOLOGY	0.158989		69.00
69.01	03140	CARDIAC REHABILITATION	0.467931		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275665		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.369155		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525267		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173649		73.00
74.00	07400	RENAL DIALYSIS	0.739579		74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.614991		90.00
91.00	09100	EMERGENCY	0.176902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.188127		92.00
OTHER REIMBURSABLE COST CENTERS					
99.30	09930	OOT			99.30
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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			Title XIX		Hospital	PPS	
			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	8,284,634	989,145	7,295,489	0	0
51.00	05100	RECOVERY ROOM	410,774	11,138	399,636	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,460,410	139,489	1,320,921	0	0
53.00	05300	ANESTHESIOLOGY	1,186,420	74,243	1,112,177	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,585,092	293,767	3,291,325	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	1,347,066	33,235	1,313,831	0	0
56.00	05600	RADIOISOTOPE	607,510	30,556	576,954	0	0
57.00	05700	CT SCAN	1,589,973	84,263	1,505,710	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	299,551	16,540	283,011	0	0
59.00	05900	CARDIAC CATHETERIZATION	137,762	42,276	95,486	0	0
60.00	06000	LABORATORY	5,020,835	229,038	4,791,797	0	0
64.00	06400	INTRAVENOUS THERAPY	650,432	33,425	617,007	0	0
65.00	06500	RESPIRATORY THERAPY	2,362,286	122,925	2,239,361	0	0
66.00	06600	PHYSICAL THERAPY	2,850,857	221,504	2,629,353	0	0
66.01	03340	CLINICAL NUTRITION	219,433	5,277	214,156	0	0
67.00	06700	OCCUPATIONAL THERAPY	231,398	5,988	225,410	0	0
68.00	06800	SPEECH PATHOLOGY	291,026	18,402	272,624	0	0
69.00	06900	ELECTROCARDIOLOGY	2,072,062	160,885	1,911,177	0	0
69.01	03140	CARDIAC REHABILITATION	273,869	6,855	267,014	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	320,985	42,508	278,477	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,159,575	131,103	6,028,472	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,136,794	24,522	1,112,272	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,627,713	104,180	4,523,533	0	0
74.00	07400	RENAL DIALYSIS	40,222	862	39,360	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,623,657	312,192	3,311,465	0	0
91.00	09100	EMERGENCY	4,841,997	290,897	4,551,100	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,639,524	139,104	1,500,420	0	0
OTHER REIMBURSABLE COST CENTERS							
99.30	09930	OOT	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	55,271,857	3,564,319	51,707,538	0	0
201.00		Less Observation Beds	1,639,524	139,104	1,500,420	0	0
202.00		Total (line 200 minus line 201)	53,632,333	3,425,215	50,207,118	0	0

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

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
7/5/2022 10:52 am

				Title XIX		Hospital	PPS		
Cost Center Description			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	8,284,634	38,829,928	0.213357			50.00	
51.00	05100	RECOVERY ROOM	410,774	4,085,220	0.100551			51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,460,410	1,974,489	0.739639			52.00	
53.00	05300	ANESTHESIOLOGY	1,186,420	11,297,576	0.105015			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,585,092	14,794,976	0.242318			54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,347,066	6,373,957	0.211339			55.00	
56.00	05600	RADIOISOTOPE	607,510	6,274,387	0.096824			56.00	
57.00	05700	CT SCAN	1,589,973	39,618,493	0.040132			57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	299,551	8,396,273	0.035677			58.00	
59.00	05900	CARDIAC CATHETERIZATION	137,762	0	0.000000			59.00	
60.00	06000	LABORATORY	5,020,835	47,949,910	0.104710			60.00	
64.00	06400	INTRAVENOUS THERAPY	650,432	1,760,480	0.369463			64.00	
65.00	06500	RESPIRATORY THERAPY	2,362,286	10,748,182	0.219785			65.00	
66.00	06600	PHYSICAL THERAPY	2,850,857	9,001,661	0.316703			66.00	
66.01	03340	CLINICAL NUTRITION	219,433	39,465	5.560193			66.01	
67.00	06700	OCCUPATIONAL THERAPY	231,398	1,037,445	0.223046			67.00	
68.00	06800	SPEECH PATHOLOGY	291,026	529,145	0.549993			68.00	
69.00	06900	ELECTROCARDIOLOGY	2,072,062	13,109,455	0.158059			69.00	
69.01	03140	CARDIAC REHABILITATION	273,869	585,276	0.467931			69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	320,985	1,179,377	0.272165			70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,159,575	4,498,815	1.369155			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,136,794	2,164,223	0.525267			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,627,713	26,649,847	0.173649			73.00	
74.00	07400	RENAL DIALYSIS	40,222	54,385	0.739579			74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,623,657	5,892,216	0.614991			90.00	
91.00	09100	EMERGENCY	4,841,997	27,533,819	0.175856			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,639,524	1,379,923	1.188127			92.00	
	OTHER REIMBURSABLE COST CENTERS								
99.30	09930	OOT	0	0	0.000000			99.30	
200.00		Subtotal (sum of lines 50 thru 199)	55,271,857	285,758,923				200.00	
201.00		Less Observation Beds	1,639,524	0				201.00	
202.00		Total (line 200 minus line 201)	53,632,333	285,758,923				202.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/5/2022 10:52 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	1,395,123	0	1,395,123	11,263	123.87	30.00
31.00	INTENSIVE CARE UNIT	224,394		224,394	1,504	149.20	31.00
40.00	SUBPROVIDER - IPF	330,496	0	330,496	5,360	61.66	40.00
43.00	NURSERY	74,746		74,746	249	300.18	43.00
200.00	Total (lines 30 through 199)	2,024,759		2,024,759	18,376		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	6,858	849,500				30.00
31.00	INTENSIVE CARE UNIT	1,362	203,210				31.00
40.00	SUBPROVIDER - IPF	291	17,943				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	8,511	1,070,653				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	989,145	38,829,928	0.025474	3,704,143	94,359	50.00
51.00	05100	RECOVERY ROOM	11,138	4,085,220	0.002726	412,300	1,124	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,489	1,974,489	0.070646	0	0	52.00
53.00	05300	ANESTHESIOLOGY	74,243	11,297,576	0.006572	643,790	4,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,767	14,794,976	0.019856	2,085,346	41,407	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,235	6,373,957	0.005214	0	0	55.00
56.00	05600	RADIOISOTOPE	30,556	6,274,387	0.004870	191,915	935	56.00
57.00	05700	CT SCAN	84,263	39,618,493	0.002127	4,507,055	9,587	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,540	8,396,273	0.001970	538,425	1,061	58.00
59.00	05900	CARDIAC CATHETERIZATION	42,276	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	229,038	47,949,910	0.004777	8,653,745	41,339	60.00
64.00	06400	INTRAVENOUS THERAPY	33,425	1,760,480	0.018986	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,925	10,748,182	0.011437	3,627,170	41,484	65.00
66.00	06600	PHYSICAL THERAPY	221,504	9,001,661	0.024607	864,790	21,280	66.00
66.01	03340	CLINICAL NUTRITION	5,277	39,465	0.133713	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,988	1,037,445	0.005772	201,560	1,163	67.00
68.00	06800	SPEECH PATHOLOGY	18,402	529,145	0.034777	120,055	4,175	68.00
69.00	06900	ELECTROCARDIOLOGY	160,885	13,109,455	0.012272	1,836,735	22,540	69.00
69.01	03140	CARDIAC REHABILITATION	6,855	585,276	0.011712	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	42,508	1,179,377	0.036043	85,200	3,071	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,103	4,498,815	0.029142	1,757,593	51,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,522	2,164,223	0.011331	446,140	5,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,180	26,649,847	0.003909	7,237,206	28,290	73.00
74.00	07400	RENAL DIALYSIS	862	54,385	0.015850	15,600	247	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	312,192	5,892,216	0.052984	490	26	90.00
91.00	09100	EMERGENCY	290,897	27,533,819	0.010565	3,104,109	32,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	139,104	1,379,923	0.100806	163,815	16,514	92.00
200.00		Total (lines 50 through 199)	3,564,319	285,758,923		40,197,182	421,903	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/5/2022 10:52 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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	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	11,263	0.00	6,858	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	1,504	0.00	1,362	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	5,360	0.00	291	40.00		
43.00	04300	NURSERY		0	249	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	18,376		8,511	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	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 am	
			Title XVIII		Hospital		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/5/2022 10:52 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	38,829,928	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,085,220	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,974,489	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,297,576	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,794,976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,373,957	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,274,387	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	39,618,493	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,396,273	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,949,910	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,760,480	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,748,182	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,001,661	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	39,465	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,037,445	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	529,145	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,109,455	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	585,276	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,179,377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,498,815	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,164,223	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,649,847	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	54,385	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,892,216	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,533,819	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,379,923	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	285,758,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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	3,704,143	0	5,822,637	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	412,300	0	2,024,610	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	2,410	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	643,790	0	1,293,865	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	2,085,346	0	9,136,140	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	75,160	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	191,915	0	1,282,200	0	56.00
57.00	05700	CT SCAN		0.000000	4,507,055	0	10,969,150	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	538,425	0	2,653,425	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	8,653,745	0	4,409,527	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	3,627,170	0	1,288,396	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	864,790	0	11,435	0	66.00
66.01	03340	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	201,560	0	2,025	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	120,055	0	2,885	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	1,836,735	0	2,893,159	0	69.00
69.01	03140	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	85,200	0	933,475	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	1,757,593	0	324,429	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	446,140	0	313,937	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	7,237,206	0	8,054,629	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	15,600	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	490	0	676,708	0	90.00
91.00	09100	EMERGENCY		0.000000	3,104,109	0	6,062,621	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	163,815	0	441,154	0	92.00
200.00		Total (lines 50 through 199)			40,197,182	0	58,673,977	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/5/2022 10:52 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	0.213357	5,822,637	0	0	1,242,300	50.00
51.00	05100	RECOVERY ROOM	0.100551	2,024,610	0	0	203,577	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.739639	2,410	0	0	1,783	52.00
53.00	05300	ANESTHESIOLOGY	0.105015	1,293,865	0	0	135,875	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242318	9,136,140	0	0	2,213,851	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.211339	75,160	0	0	15,884	55.00
56.00	05600	RADIOISOTOPE	0.096824	1,282,200	0	0	124,148	56.00
57.00	05700	CT SCAN	0.040132	10,969,150	0	0	440,214	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.035677	2,653,425	0	0	94,666	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.104710	4,409,527	1,895	0	461,722	60.00
64.00	06400	INTRAVENOUS THERAPY	0.369463	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.219785	1,288,396	0	0	283,170	65.00
66.00	06600	PHYSICAL THERAPY	0.316703	11,435	0	0	3,621	66.00
66.01	03340	CLINICAL NUTRITION	5.560193	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.223046	2,025	0	0	452	67.00
68.00	06800	SPEECH PATHOLOGY	0.549993	2,885	0	0	1,587	68.00
69.00	06900	ELECTROCARDIOLOGY	0.158059	2,893,159	0	0	457,290	69.00
69.01	03140	CARDIAC REHABILITATION	0.467931	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.272165	933,475	0	0	254,059	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.369155	324,429	0	0	444,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525267	313,937	0	0	164,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173649	8,054,629	0	46,517	1,398,678	73.00
74.00	07400	RENAL DIALYSIS	0.739579	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.614991	676,708	0	110	416,169	90.00
91.00	09100	EMERGENCY	0.175856	6,062,621	0	0	1,066,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.188127	441,154	0	0	524,147	92.00
200.00		Subtotal (see instructions)		58,673,977	1,895	46,627	9,948,436	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		58,673,977	1,895	46,627	9,948,436	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/5/2022 10:52 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	198	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03340	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03140	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,078		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	68		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)	198	8,146		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	198	8,146		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 7/5/2022 10:52 am	
					Component CCN: 14-S034			
					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	989,145	38,829,928	0.025474	0	0	50.00
51.00	05100	RECOVERY ROOM	11,138	4,085,220	0.002726	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,489	1,974,489	0.070646	0	0	52.00
53.00	05300	ANESTHESIOLOGY	74,243	11,297,576	0.006572	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,767	14,794,976	0.019856	1,920	38	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,235	6,373,957	0.005214	0	0	55.00
56.00	05600	RADIOISOTOPE	30,556	6,274,387	0.004870	0	0	56.00
57.00	05700	CT SCAN	84,263	39,618,493	0.002127	24,800	53	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,540	8,396,273	0.001970	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	42,276	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	229,038	47,949,910	0.004777	58,495	279	60.00
64.00	06400	INTRAVENOUS THERAPY	33,425	1,760,480	0.018986	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,925	10,748,182	0.011437	27,640	316	65.00
66.00	06600	PHYSICAL THERAPY	221,504	9,001,661	0.024607	6,640	163	66.00
66.01	03340	CLINICAL NUTRITION	5,277	39,465	0.133713	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,988	1,037,445	0.005772	2,415	14	67.00
68.00	06800	SPEECH PATHOLOGY	18,402	529,145	0.034777	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	160,885	13,109,455	0.012272	3,160	39	69.00
69.01	03140	CARDIAC REHABILITATION	6,855	585,276	0.011712	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	42,508	1,179,377	0.036043	1,210	44	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,103	4,498,815	0.029142	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,522	2,164,223	0.011331	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,180	26,649,847	0.003909	30,779	120	73.00
74.00	07400	RENAL DIALYSIS	862	54,385	0.015850	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,192	5,892,216	0.052984	0	0	90.00
91.00	09100	EMERGENCY	290,897	27,533,819	0.010565	24,215	256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,379,923	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,425,215	285,758,923		181,274	1,322	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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	38,829,928	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,085,220	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,974,489	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,297,576	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,794,976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,373,957	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,274,387	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	39,618,493	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,396,273	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,949,910	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,760,480	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,748,182	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,001,661	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	39,465	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,037,445	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	529,145	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,109,455	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	585,276	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,179,377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,498,815	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,164,223	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,649,847	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	54,385	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,892,216	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,533,819	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,379,923	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	285,758,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

Period:

Worksheet D

Component CCN: 14-S034

From 01/01/2021
To 12/31/2021

Part IV
Date/Time Prepared:
7/5/2022 10:52 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	1,920	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	24,800	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	58,495	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	27,640	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	6,640	0	0	0	66.00	
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,415	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,160	0	0	0	69.00	
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,210	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	30,779	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	500	0	90.00	
91.00	09100	EMERGENCY	0.000000	24,215	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)			181,274	0	500	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:

Worksheet D

Component CCN: 14-S034

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
7/5/2022 10:52 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	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.213357	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.100551	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.739639	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105015	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242318	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.211339	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.096824	0	0	0	0	56.00
57.00	05700	CT SCAN	0.040132	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.035677	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.104710	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.369463	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.219785	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.316703	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	5.560193	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.223046	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.549993	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.158059	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.467931	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.272165	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.369155	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525267	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173649	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.739579	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.614991	500	0	0	307	90.00
91.00	09100	EMERGENCY	0.175856	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.188127	0	0	0	0	92.00
200.00		Subtotal (see instructions)		500	0	0	307	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		500	0	0	307	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034

Period:

Worksheet D

Component CCN: 14-S034

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
7/5/2022 10:52 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	03340	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03140	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	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	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/5/2022 10:52 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	1,395,123	0	1,395,123	11,263	123.87	30.00
31.00	INTENSIVE CARE UNIT	224,394		224,394	1,504	149.20	31.00
40.00	SUBPROVIDER - IPF	330,496	0	330,496	5,360	61.66	40.00
43.00	NURSERY	74,746		74,746	249	300.18	43.00
200.00	Total (lines 30 through 199)	2,024,759		2,024,759	18,376		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	243	30,100				
31.00	INTENSIVE CARE UNIT	128	19,098				
40.00	SUBPROVIDER - IPF	308	18,991				
43.00	NURSERY	49	14,709				
200.00	Total (lines 30 through 199)	728	82,898				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/5/2022 10:52 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	989,145	38,829,928	0.025474	0	0 50.00
51.00	05100	RECOVERY ROOM	11,138	4,085,220	0.002726	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,489	1,974,489	0.070646	0	0 52.00
53.00	05300	ANESTHESIOLOGY	74,243	11,297,576	0.006572	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,767	14,794,976	0.019856	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,235	6,373,957	0.005214	0	0 55.00
56.00	05600	RADIOISOTOPE	30,556	6,274,387	0.004870	0	0 56.00
57.00	05700	CT SCAN	84,263	39,618,493	0.002127	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,540	8,396,273	0.001970	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	42,276	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	229,038	47,949,910	0.004777	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	33,425	1,760,480	0.018986	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	122,925	10,748,182	0.011437	0	0 65.00
66.00	06600	PHYSICAL THERAPY	221,504	9,001,661	0.024607	0	0 66.00
66.01	03340	CLINICAL NUTRITION	5,277	39,465	0.133713	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	5,988	1,037,445	0.005772	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	18,402	529,145	0.034777	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	160,885	13,109,455	0.012272	0	0 69.00
69.01	03140	CARDIAC REHABILITATION	6,855	585,276	0.011712	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	42,508	1,179,377	0.036043	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,103	4,498,815	0.029142	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,522	2,164,223	0.011331	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,180	26,649,847	0.003909	0	0 73.00
74.00	07400	RENAL DIALYSIS	862	54,385	0.015850	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	312,192	5,892,216	0.052984	0	0 90.00
91.00	09100	EMERGENCY	290,897	27,533,819	0.010565	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	139,104	1,379,923	0.100806	0	0 92.00
200.00		Total (lines 50 through 199)	3,564,319	285,758,923		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/5/2022 10:52 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	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00			
43.00	04300	NURSERY	0	0	0	0	0	43.00			
200.00		Total (lines 30 through 199)	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	11,263	0.00	243	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	1,504	0.00	128	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	5,360	0.00	308	40.00			
43.00	04300	NURSERY	0	0	249	0.00	49	43.00			
200.00		Total (lines 30 through 199)	0	0	18,376		728	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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/5/2022 10:52 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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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	38,829,928	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,085,220	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,974,489	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,297,576	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,794,976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,373,957	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6,274,387	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	39,618,493	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	8,396,273	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	47,949,910	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,760,480	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,748,182	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,001,661	0.000000	66.00
66.01	03340	CLINICAL NUTRITION	0	0	0	39,465	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,037,445	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	529,145	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,109,455	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION	0	0	0	585,276	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,179,377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,498,815	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,164,223	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,649,847	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	54,385	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,892,216	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	27,533,819	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,379,923	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	285,758,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/5/2022 10:52 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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
66.01	03340	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 7/5/2022 10:52 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	989,145	38,829,928	0.025474	0	0	0	50.00
51.00	05100	RECOVERY ROOM	11,138	4,085,220	0.002726	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,489	1,974,489	0.070646	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	74,243	11,297,576	0.006572	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,767	14,794,976	0.019856	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	33,235	6,373,957	0.005214	0	0	0	55.00
56.00	05600	RADIOISOTOPE	30,556	6,274,387	0.004870	0	0	0	56.00
57.00	05700	CT SCAN	84,263	39,618,493	0.002127	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,540	8,396,273	0.001970	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	42,276	0	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	229,038	47,949,910	0.004777	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	33,425	1,760,480	0.018986	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,925	10,748,182	0.011437	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	221,504	9,001,661	0.024607	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION	5,277	39,465	0.133713	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	5,988	1,037,445	0.005772	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,402	529,145	0.034777	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	160,885	13,109,455	0.012272	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION	6,855	585,276	0.011712	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	42,508	1,179,377	0.036043	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,103	4,498,815	0.029142	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,522	2,164,223	0.011331	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,180	26,649,847	0.003909	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	862	54,385	0.015850	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	312,192	5,892,216	0.052984	0	0	0	90.00
91.00	09100	EMERGENCY	290,897	27,533,819	0.010565	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,379,923	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)	3,425,215	285,758,923		0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
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: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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	38,829,928	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	4,085,220	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,974,489	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	11,297,576	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	14,794,976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	6,373,957	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	6,274,387	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	39,618,493	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	8,396,273	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	47,949,910	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	1,760,480	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	10,748,182	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	9,001,661	0.000000	66.00
66.01	03340	CLINICAL NUTRITION		0	0	0	39,465	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,037,445	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	529,145	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	13,109,455	0.000000	69.00
69.01	03140	CARDIAC REHABILITATION		0	0	0	585,276	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,179,377	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	4,498,815	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	2,164,223	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	26,649,847	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	54,385	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,892,216	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	27,533,819	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	1,379,923	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	285,758,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/5/2022 10:52 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
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
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
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
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
66.01	03340	CLINICAL NUTRITION		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
69.01	03140	CARDIAC REHABILITATION		0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		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
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: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/5/2022 10:52 am	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			11,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,263	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)			10,140	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)			6,858	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)			16,443,377	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)			16,443,377	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)			16,443,377	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,459.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			10,012,337	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)			10,012,337	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/5/2022 10:52 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	4,594,321	1,504	3,054.73	1,362	4,160,542
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)					8,684,540
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,857,419
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,052,710
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					421,903
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,474,613
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,382,806
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,123
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,459.95
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,639,524

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/5/2022 10:52 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,395,123	16,443,377	0.084844	1,639,524	139,104	90.00
91.00 Nursing Program cost	0	16,443,377	0.000000	1,639,524	0	91.00
92.00 Allied health cost	0	16,443,377	0.000000	1,639,524	0	92.00
93.00 All other Medical Education	0	16,443,377	0.000000	1,639,524	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/5/2022 10:52 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)		5,360	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,360	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)		5,360	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)		291	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,180,442	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,180,442	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,180,442	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,153.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		335,543	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)		335,543	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 7/5/2022 10:52 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)					26,783	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					362,326	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)					17,943	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,322	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					19,265	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					343,061	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: 14-0034

Period:

Worksheet D-1

Component CCN: 14-S034

From 01/01/2021
To 12/31/2021Date/Time Prepared:
7/5/2022 10:52 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	330,496	6,180,442	0.053474	0	0	90.00
91.00	Nursing Program cost	0	6,180,442	0.000000	0	0	91.00
92.00	Allied health cost	0	6,180,442	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,180,442	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/5/2022 10:52 am	
Cost Center Description		Title XIX	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			11,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,263	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)			10,140	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)			243	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)			249	15.00
16.00	Nursery days (title V or XIX only)			49	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)			16,443,377	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)			16,443,377	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)			16,443,377	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,459.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			354,768	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)			354,768	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/5/2022 10:52 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)	451,113	249	1,811.70	49	88,773	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,594,321	1,504	3,054.73	128	391,005	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)						834,546 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)						63,907 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)						63,907 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						770,639 53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)						1,123 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,459.95 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,639,524 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034

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

Worksheet D-1

Date/Time Prepared:
7/5/2022 10:52 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	1,395,123	16,443,377	0.084844	1,639,524	139,104
91.00	Nursing Program cost	0	16,443,377	0.000000	1,639,524	0
92.00	Allied health cost	0	16,443,377	0.000000	1,639,524	0
93.00	All other Medical Education	0	16,443,377	0.000000	1,639,524	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/5/2022 10:52 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)		5,360	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,360	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)		5,360	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)		308	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)		249	15.00
16.00	Nursery days (title V or XIX only)		49	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,180,442	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,180,442	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,180,442	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,153.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		355,146	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)		355,146	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0034 Component CCN: 14-S034		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 7/5/2022 10:52 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	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)					355,146	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)					18,991	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)					18,991	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					336,155	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: 14-0034

Period:

Worksheet D-1

Component CCN: 14-S034

From 01/01/2021
To 12/31/2021Date/Time Prepared:
7/5/2022 10:52 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	330,496	6,180,442	0.053474	0	0	90.00
91.00	Nursing Program cost	0	6,180,442	0.000000	0	0	91.00
92.00	Allied health cost	0	6,180,442	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,180,442	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/5/2022 10:52 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		11,612,145		30.00
31.00	03100	INTENSIVE CARE UNIT		2,019,820		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	0.213942	3,704,143	792,472	50.00
51.00	05100	RECOVERY ROOM	0.100551	412,300	41,457	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.739639	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105015	643,790	67,608	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242318	2,085,346	505,317	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.211339	0	0	55.00
56.00	05600	RADIOISOTOPE	0.096824	191,915	18,582	56.00
57.00	05700	CT SCAN	0.040132	4,507,055	180,877	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.035677	538,425	19,209	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.104806	8,653,745	906,964	60.00
64.00	06400	INTRAVENOUS THERAPY	0.369463	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.220169	3,627,170	798,590	65.00
66.00	06600	PHYSICAL THERAPY	0.316703	864,790	273,882	66.00
66.01	03340	CLINICAL NUTRITION	5.560193	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.223046	201,560	44,957	67.00
68.00	06800	SPEECH PATHOLOGY	0.549993	120,055	66,029	68.00
69.00	06900	ELECTROCARDIOLOGY	0.158989	1,836,735	292,021	69.00
69.01	03140	CARDIAC REHABILITATION	0.467931	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.275665	85,200	23,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.369155	1,757,593	2,406,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525267	446,140	234,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173649	7,237,206	1,256,734	73.00
74.00	07400	RENAL DIALYSIS	0.739579	15,600	11,537	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.614991	490	301	90.00
91.00	09100	EMERGENCY	0.176902	3,104,109	549,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.188127	163,815	194,633	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,197,182	8,684,540	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)		40,197,182		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/5/2022 10:52 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		375,885		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.213942	0	0	50.00
51.00	05100 RECOVERY ROOM	0.100551	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.739639	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.105015	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.242318	1,920	465	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.211339	0	0	55.00
56.00	05600 RADIOISOTOPE	0.096824	0	0	56.00
57.00	05700 CT SCAN	0.040132	24,800	995	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.035677	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.104806	58,495	6,131	60.00
64.00	06400 INTRAVENOUS THERAPY	0.369463	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.220169	27,640	6,085	65.00
66.00	06600 PHYSICAL THERAPY	0.316703	6,640	2,103	66.00
66.01	03340 CLINICAL NUTRITION	5.560193	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.223046	2,415	539	67.00
68.00	06800 SPEECH PATHOLOGY	0.549993	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.158989	3,160	502	69.00
69.01	03140 CARDIAC REHABILITATION	0.467931	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.275665	1,210	334	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.369155	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.525267	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173649	30,779	5,345	73.00
74.00	07400 RENAL DIALYSIS	0.739579	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.614991	0	0	90.00
91.00	09100 EMERGENCY	0.176902	24,215	4,284	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.188127	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		181,274	26,783	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)		181,274	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/5/2022 10:52 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)		10,220,007	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,333,501	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)		266,001	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		103,055	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)		96.92	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)		4.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.54	31.00
32.00	Sum of lines 30 and 31		24.13	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.14	33.00
34.00	Disproportionate share adjustment (see instructions)		309,698	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/5/2022 10:52 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,290,014,521	7,192,008,710
35.01	Factor 3 (see instructions)		0.000095614	0.000069147
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		792,643	497,303
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		592,853	125,348
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		718,201	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		14,950,463	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		15,162,898	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		15,109,789	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,062,061	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		269,018	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)		16,440,868	59.00
60.00	Primary payer payments		18,681	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,422,187	61.00
62.00	Deductibles billed to program beneficiaries		1,649,716	62.00
63.00	Coinsurance billed to program beneficiaries		50,751	63.00
64.00	Allowable bad debts (see instructions)		566,550	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		368,258	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		480,634	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,089,978	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)		1,095	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)		95,428	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/5/2022 10:52 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)		15,186,501	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		15,722,377	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-535,876	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		398,956	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)		119,167	40,159
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		1.0091899972	1.0000000000
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		1,095	0
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		1.0000	1.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/5/2022 10:52 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	10,220,007	0	10,220,007		10,220,007
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,333,501	0		3,333,501	3,333,501
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	266,001	0	266,001		266,001
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103,055	0		103,055	103,055
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	0.0914	0.0914	0.0914	0.0914	
11.00	Disproportionate share adjustment (see instructions)	34.00	309,698	0	233,527	76,171	309,698
11.01	Uncompensated care payments	36.00	718,201	0	718,201	0	718,201
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	14,950,463	0	11,437,736	3,512,727	14,950,463
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	15,162,898	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,109,789	0	11,597,062	3,512,727	15,109,789
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,062,061	0	798,503	263,558	1,062,061

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/5/2022 10:52 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	269,018	0	164,056	104,962	269,018	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	12,559,621	3,881,247	16,440,868	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	1,024,766	0	775,164	249,602	1,024,766	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	37,295	0	23,339	13,956	37,295	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,062,061	0	798,503	263,558	1,062,061	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: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/5/2022 10:52 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	10,220,007	10,220,007		10,220,007	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,333,501		3,333,501	3,333,501	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	266,001	266,001		266,001	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	103,055		103,055	103,055	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	0.0914	0.0914	0.0914		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	309,698	233,527	76,171	309,698	11.00
11.01	Uncompensated care payments	36.00	718,201	4,343	0	4,343	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	14,950,463	11,437,736	3,512,727	14,950,463	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	15,162,898	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,109,789	11,597,062	3,512,727	15,109,789	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,062,061	798,503	263,558	1,062,061	16.00
17.00	Special add-on payments for new technologies	54.00	269,018	164,056	104,962	269,018	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			12,559,621	3,881,247	16,440,868	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/5/2022 10:52 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	1,024,766	775,164	249,602	1,024,766	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	37,295	23,339	13,956	37,295	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,062,061	798,503	263,558	1,062,061	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	95,428	95,428	0	95,428	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	1,095	1,095	0	1,095	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	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: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/5/2022 10:52 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,344	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,948,436	2.00
3.00	OPPS payments		8,683,201	3.00
4.00	Outlier payment (see instructions)		15,786	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)		8,344	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		48,522	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)		48,522	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)		48,522	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		40,178	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)		8,344	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)		8,698,987	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,691,020	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		7,016,311	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)		7,016,311	30.00
31.00	Primary payer payments		569	31.00
32.00	Subtotal (line 30 minus line 31)		7,015,742	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)		467,230	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		303,700	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		358,595	36.00
37.00	Subtotal (see instructions)		7,319,442	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-31	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)		7,319,473	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		7,281,120	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)		38,353	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: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/5/2022 10:52 am
		Title XVIII	Hospital	PPS
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/5/2022 10:52 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		307	2.00
3.00	OPPS payments		121	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		121	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)		24	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)		97	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)		97	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		97	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)		97	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)		97	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		97	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)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/5/2022 10:52 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
7/5/2022 10:52 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		15,682,861		7,013,828	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		374,127		203,824	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	10/04/2021	63,468	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	10/04/2021	334,611		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)		-334,611		63,468	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)		15,722,377		7,281,120	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		38,353	6.01	
6.02	SETTLEMENT TO PROGRAM		535,876		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,186,501		7,319,473	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: 14-0034

Period:

Worksheet E-1

Component CCN: 14-S034

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/5/2022 10:52 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		287,574		97	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)		287,574		97	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		21,590		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		309,164		97	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: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 7/5/2022 10:52 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: 14-0034 Component CCN: 14-S034	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 7/5/2022 10:52 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)			294,994 1.00
2.00	Net IPF PPS Outlier Payments			0 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)			14.684932 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)			294,994 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)			294,994 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			294,994 18.00
19.00	Deductibles			7,420 19.00
20.00	Subtotal (line 18 minus line 19)			287,574 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			287,574 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			33,215 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			21,590 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			17,676 25.00
26.00	Subtotal (sum of lines 22 and 24)			309,164 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)			309,164 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			287,574 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)			21,590 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			0 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/5/2022 10:52 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	8,511	1,449		26.00
27.00	Total Inpatient Days (see instructions)	17,075	17,075		27.00
28.00	Ratio of inpatient days to total inpatient days	0.498448	0.084861		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/5/2022 10:52 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		54,385		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		23,219,745		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		18,681		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		23,201,064		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		9,957,087		42.00
43.00	Primary payer payments (see instructions)		569		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		9,956,518		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		33,157,582		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.699721		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.300279		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		0		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		0		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		0		50.00

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

Provider CCN: 14-0034

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

Worksheet G

Date/Time Prepared:
7/5/2022 10:52 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	102,046	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	31,630,708	0	0	0	4.00
5.00 Other receivable	1,035,041	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-13,476,095	0	0	0	6.00
7.00 Inventory	2,170,972	0	0	0	7.00
8.00 Prepaid expenses	585,318	0	0	0	8.00
9.00 Other current assets	977,669	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	23,025,659	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,259,000	0	0	0	12.00
13.00 Land improvements	714,463	0	0	0	13.00
14.00 Accumulated depreciation	-672,221	0	0	0	14.00
15.00 Buildings	46,038,906	0	0	0	15.00
16.00 Accumulated depreciation	-20,428,482	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	5,414,481	0	0	0	19.00
20.00 Accumulated depreciation	-2,984,662	0	0	0	20.00
21.00 Automobiles and trucks	233,644	0	0	0	21.00
22.00 Accumulated depreciation	-187,320	0	0	0	22.00
23.00 Major movable equipment	33,638,889	0	0	0	23.00
24.00 Accumulated depreciation	-23,496,938	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)	39,529,760	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	1,051,114	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	-601,038	588,077	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	450,076	588,077	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	63,005,495	588,077	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	-45,519,006	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,742,712	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	358,181	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	8,831,057	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	-32,587,056	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	59,399,230	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	59,399,230	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	26,812,174	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	36,193,321				52.00
53.00 Specific purpose fund		588,077			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)	36,193,321	588,077	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	63,005,495	588,077	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0034

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

Worksheet G-1

Date/Time Prepared:
7/5/2022 10:52 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		18,408,466		822,359		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,596,623				2.00
3.00	Total (sum of line 1 and line 2)		36,005,089		822,359		3.00
4.00	RELATED PARTY TRANSFERS	188,232		-234,282		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)		188,232		-234,282		10.00
11.00	Subtotal (line 3 plus line 10)		36,193,321		588,077		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,193,321		588,077		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	RELATED PARTY TRANSFERS		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	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0034

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/5/2022 10:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,458,258		19,458,258	1.00
2.00	SUBPROVIDER - IPF	7,006,653		7,006,653	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	26,464,911		26,464,911	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,197,005		4,197,005	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)	4,197,005		4,197,005	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,661,916		30,661,916	17.00
18.00	Ancillary services	73,548,036	177,613,485	251,161,521	18.00
19.00	Outpatient services	7,472,752	27,124,649	34,597,401	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.30	OOT	0	0	0	24.30
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE	0	43,677	43,677	27.00
27.01	ORGAN ACQUISITION CHARGES	0	0	0	27.01
27.02	PROFESSIONAL FEES	3,398,723	2,894,932	6,293,655	27.02
27.03	EMPLOYEE CHARGES	1,568,755	4,816,923	6,385,678	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	116,650,182	212,493,666	329,143,848	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		101,909,871		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)		101,909,871		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0034

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

Worksheet G-3

Date/Time Prepared:
7/5/2022 10:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	329,143,848	1.00
2.00	Less contractual allowances and discounts on patients' accounts	216,924,547	2.00
3.00	Net patient revenues (line 1 minus line 2)	112,219,301	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	101,909,871	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,309,430	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,075,626	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	284	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	212,005	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	226,744	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	5,534,508	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,049,167	25.00
26.00	Total (line 5 plus line 25)	18,358,597	26.00
27.00	NON OPERATING GAINS AND LOSSES	761,974	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	761,974	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,596,623	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0034	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 7/5/2022 10:52 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,024,766	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		37,295	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)		32.33	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,062,061	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