

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: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 9:26 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/29/2021	Time: 9:26 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GALESBURG COTTAGE HOSPITAL (14-0040) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) SANJAY SHARMA

Officer or Administrator of Provider(s)

CEO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-145,847	-101,223	0	0	1.00
2.00	Subprovider - IPF	0	0	-163		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-145,847	-101,386	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: 14-0040		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 9:26 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 695 NORTH KELLOGG STREET			PO Box:				1.00	
2.00	City: GALESBURG			State: IL		Zip Code: 61401		County: KNOX 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N P P
4.00	Subprovider - IPF			GALESBURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N P N
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2020	04/30/2021	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	123	0	0	0	315	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					05/01/2020	04/30/2021	38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0040		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 9:26 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		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
			1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

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

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N 80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N 81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N 85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N 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
			1.00	2.00
			Speech	Respiratory
			3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
			1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N 110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 9:26 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 9:26 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:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		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.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	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	
						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
						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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 9:26 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	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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 nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		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
			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)	Y	08/26/2021	Y	08/26/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 9:26 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	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	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.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	STEC	41.00
42.00	Enter the employer/company name of the cost report preparer.	THE RYBAR GROUP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	989-305-0136	ESTEC@THERYBARGROUP.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 9:26 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.	REIMBURSEMENT CONSULTANT	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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 9:26 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	84	30,744	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)		84	30,744	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	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)		96	35,136	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,856		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		112			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 9:26 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)	1,361	35	2,647			1.00
2.00	HMO and other (see instructions)	515	315				2.00
3.00	HMO IPF Subprovider	592	34				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)	1,361	35	2,647			7.00
8.00	INTENSIVE CARE UNIT	341	88	589			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,702	123	3,236	0.00	0.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,427	0	4,310	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	0.00	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 9:26 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	421	0	884	1.00
2.00 HMO and other (see instructions)			120	25		2.00
3.00 HMO IPF Subprovider				139		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	421	0	884	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	106	2	193	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 9:26 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	758,561	0	758,561	25,809.08	29.39
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		118,818	929	119,747	5,210.03	22.98
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		240,288	0	240,288	4,285.50	56.07
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
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)		371,078	0	371,078		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		58,124	0	58,124		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

11/29/2021 9:26 am

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 9:26 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	10,794	0	10,794	365.24	29.55	26.00
27.00	Administrative & General	5.00	95,211	-10,151	85,060	4,497.87	18.91	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	18,312	0	18,312	681.42	26.87	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	19,337	0	19,337	1,640.90	11.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	68,355	3,255	71,610	1,939.43	36.92	38.00
39.00	Central Services and Supply	14.00	3,421	0	3,421	230.93	14.81	39.00
40.00	Pharmacy	15.00	28,655	0	28,655	771.42	37.15	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/29/2021 9:26 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)	758,561	0	758,561	25,809.08	29.39	1.00
2.00	Excluded area salaries (see instructions)	118,818	929	119,747	5,210.03	22.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	639,743	-929	638,814	20,599.05	31.01	3.00
4.00	Subtotal other wages & related costs (see inst.)	240,288	0	240,288	4,285.50	56.07	4.00
5.00	Subtotal wage-related costs (see inst.)	371,078	0	371,078	0.00	58.09	5.00
6.00	Total (sum of lines 3 thru 5)	1,251,109	-929	1,250,180	24,884.55	50.24	6.00
7.00	Total overhead cost (see instructions)	244,085	-6,896	237,189	10,127.21	23.42	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/29/2021 9:26 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)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	148,578	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	733	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	188,342	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	71,672	17.00
18.00	Medicare Taxes - Employers Portion Only	16,762	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	3,848	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	429,935	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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/29/2021 9:26 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	240,288	429,202	1.00
2.00	Hospital	240,288	429,202	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet S-10

Date/Time Prepared:
11/29/2021 9:26 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)		0.046611	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,025,447	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,120,979	5.00
6.00	Medicaid charges		47,349,576	6.00
7.00	Medicaid cost (line 1 times line 6)		2,207,011	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)		0	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)		0	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)	17,913	0	17,913
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	835	0	835
22.00	Payments received from patients for amounts previously written off as charity care	2,302	0	2,302
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			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)		96,272	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		0	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		0	27.01
28.00	Non-Medicare bad debt expense (see instructions)		96,272	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,487	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,487	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,487	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		175,708	175,708	252,450	428,158 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		96,208	96,208	125,990	222,198 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,794	30,568	41,362	620,545	661,907 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	95,211	3,447,081	3,542,292	-937,960	2,604,332 5.00
7.00	00700	OPERATION OF PLANT	18,312	928,724	947,036	-6,333	940,703 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,681	97,681	0	97,681 8.00
9.00	00900	HOUSEKEEPING	19,337	142,758	162,095	0	162,095 9.00
10.00	01000	DIETARY	0	840,990	840,990	-23,943	817,047 10.00
11.00	01100	CAFETERIA	0	0	0	23,943	23,943 11.00
13.00	01300	NURSING ADMINISTRATION	68,355	63,222	131,577	974	132,551 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,421	1,799,538	1,802,959	-1,506,431	296,528 14.00
15.00	01500	PHARMACY	28,655	463,079	491,734	-350,320	141,414 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	150,262	150,262	-4,434	145,828 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	98,582	863,794	962,376	-1,336	961,040 30.00
31.00	03100	INTENSIVE CARE UNIT	79,371	265,437	344,808	-1,256	343,552 31.00
40.00	04000	SUBPROVIDER - IPF	112,717	86,812	199,529	-632	198,897 40.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,807	484,583	528,390	-37,504	490,886 50.00
51.00	05100	RECOVERY ROOM	-13,326	9,026	-4,300	4,299	-1 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	941,969	941,969	0	941,969 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,165	342,411	390,576	239,296	629,872 54.00
54.01	05401	ULTRASOUND	6,844	5,094	11,938	-11,938	0 54.01
56.00	05600	RADIOISOTOPE	6,340	144,717	151,057	-151,057	0 56.00
57.00	05700	CT SCAN	273	39,674	39,947	-39,947	0 57.00
58.00	05800	MRI	3,475	47,916	51,391	-51,391	0 58.00
60.00	06000	LABORATORY	58,874	1,289,419	1,348,293	-7,125	1,341,168 60.00
65.00	06500	RESPIRATORY THERAPY	1,615	60,584	62,199	-1,291	60,908 65.00
66.00	06600	PHYSICAL THERAPY	0	229,214	229,214	155,054	384,268 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87,636	87,636	-87,636	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	67,418	67,418	-67,418	0 68.00
69.00	06900	ELECTROCARDIOLOGY	-5,167	161,513	156,346	3,108	159,454 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	787,570	787,570 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	709,777	709,777 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	335,682	335,682 73.00
74.00	07400	RENAL DIALYSIS	0	128,667	128,667	0	128,667 74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	-795	1,966	1,171	-1,171	0 76.01
76.03	03950	WOUND CARE	4,671	468,732	473,403	-618	472,785 76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	62,929	189,230	252,159	256,497	508,656 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,967	263,951	269,918	-269,918	0 95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	758,427	14,415,582	15,174,009	-44,474	15,129,535 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	134	2,325	2,459	0	2,459 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	46,580	46,580	-298	46,282 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	07951	MARKETING	0	0	0	44,772	44,772 194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0 194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0 194.03
194.04	07954	GUEST MEALS	0	0	0	0	0 194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	758,561	14,464,487	15,223,048	0	15,223,048 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-391,810	36,348	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	222,198	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-512	661,395	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-336,413	2,267,919	5.00
7.00	00700	OPERATION OF PLANT	0	940,703	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,681	8.00
9.00	00900	HOUSEKEEPING	0	162,095	9.00
10.00	01000	DIETARY	0	817,047	10.00
11.00	01100	CAFETERIA	0	23,943	11.00
13.00	01300	NURSING ADMINISTRATION	0	132,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	296,528	14.00
15.00	01500	PHARMACY	0	141,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-99	145,729	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-732,669	228,371	30.00
31.00	03100	INTENSIVE CARE UNIT	0	343,552	31.00
40.00	04000	SUBPROVIDER - IPF	0	198,897	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	490,886	50.00
51.00	05100	RECOVERY ROOM	0	-1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-914,361	27,608	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	629,872	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-45,000	1,296,168	60.00
65.00	06500	RESPIRATORY THERAPY	0	60,908	65.00
66.00	06600	PHYSICAL THERAPY	0	384,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	159,454	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	787,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	709,777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	335,682	73.00
74.00	07400	RENAL DIALYSIS	0	128,667	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03950	WOUND CARE	0	472,785	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-312,071	196,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,732,935	12,396,600	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	2,459	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	46,282	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	MARKETING	0	44,772	194.01
194.02	07952	SENIOR CIRCLE	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	194.03
194.04	07954	GUEST MEALS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,732,935	12,490,113	200.00

RECLASSIFICATIONS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	621,237		1.00
	0		0	621,237		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	115,074		1.00
	0		0	115,074		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	125,650		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
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	125,650		
	D - OTHER CAP COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	187,989		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	64,461		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	340		3.00
	0		0	252,790		
	E - MARKETING DEPT					
1.00	MARKETING	194.01	6,896	37,876		1.00
	0		6,896	37,876		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	683,289		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	709,777		2.00
	0		0	1,393,066		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	335,682		1.00
	0		0	335,682		
	I - THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	155,054		1.00
2.00		0.00	0	0		2.00
	0		0	155,054		
	J - MISCELLANEOUS DEPTS					
1.00	NURSING ADMINISTRATION	13.00	3,255	3,559		1.00
2.00	OPERATING ROOM	50.00	0	8,372		2.00
3.00	RESPIRATORY THERAPY	65.00	0	1,966		3.00
4.00	EMERGENCY	91.00	5,967	263,951		4.00
5.00	RECOVERY ROOM	51.00	13,326	0		5.00
6.00	SLEEP LAB	76.01	795	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	5,167	0		7.00
	0		28,510	277,848		
	K - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	16,932	223,488		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
	0		16,932	223,488		
	L - DIETARY TO CAFETERIA					
1.00	CAFETERIA	11.00	0	23,943		1.00
	0		0	23,943		
500.00	Grand Total: Increases		52,338	3,561,708		500.00

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RECLASSIFICATIONS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
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	Decreases							11/29/2021 9:26 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	621,237	0			1.00
	0		0	621,237				
	B - OXYGEN COSTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	115,074	0			1.00
	0		0	115,074				
	C - RENTAL AND LEASE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	692	10			1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	12,347	0			2.00
3.00	OPERATION OF PLANT	7.00	0	6,333	0			3.00
4.00	NURSING ADMINISTRATION	13.00	0	5,840	0			4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,084	0			5.00
6.00	PHARMACY	15.00	0	14,638	0			6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,434	0			7.00
8.00	ADULTS & PEDIATRICS	30.00	0	1,336	0			8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,256	0			9.00
10.00	SUBPROVIDER - IPF	40.00	0	632	0			10.00
11.00	OPERATING ROOM	50.00	0	27,383	0			11.00
12.00	RECOVERY ROOM	51.00	0	655	0			12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,124	0			13.00
14.00	CT SCAN	57.00	0	13,182	0			14.00
15.00	MRI	58.00	0	731	0			15.00
16.00	LABORATORY	60.00	0	7,125	0			16.00
17.00	RESPIRATORY THERAPY	65.00	0	2,462	0			17.00
18.00	ELECTROCARDIOLOGY	69.00	0	2,059	0			18.00
19.00	WOUND CARE	76.03	0	618	0			19.00
20.00	EMERGENCY	91.00	0	13,421	0			20.00
21.00	PHYSICIANS PRIVATE OFFICES	192.00	0	298	0			21.00
	0		0	125,650				
	D - OTHER CAP COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	252,790	12			1.00
2.00		0.00	0	0	13			2.00
3.00		0.00	0	0	12			3.00
	0		0	252,790				
	E - MARKETING DEPT							
1.00	ADMINISTRATIVE & GENERAL	5.00	6,896	37,876	0			1.00
	0		6,896	37,876				
	F - MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,793	0			1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,382,273	0			2.00
	0		0	1,393,066				
	G - COST OF DRUGS/IV SOLUTIONS							
1.00	PHARMACY	15.00	0	335,682	0			1.00
	0		0	335,682				
	I - THERAPY COSTS							
1.00	OCCUPATIONAL THERAPY	67.00	0	87,636	0			1.00
2.00	SPEECH PATHOLOGY	68.00	0	67,418	0			2.00
	0		0	155,054				
	J - MISCELLANEOUS DEPTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	3,255	3,559	0			1.00
2.00	RECOVERY ROOM	51.00	0	8,372	0			2.00
3.00	SLEEP LAB	76.01	0	1,966	0			3.00
4.00	AMBULANCE SERVICES	95.00	5,967	263,951	0			4.00
5.00	OPERATING ROOM	50.00	18,493	0	0			5.00
6.00	RESPIRATORY THERAPY	65.00	795	0	0			6.00
7.00		0.00	0	0	0			7.00
	0		28,510	277,848				
	K - OTHER RADIOLOGY COSTS							
1.00	ULTRASOUND	54.01	6,844	5,094	0			1.00
2.00	RADIOISOTOPE	56.00	6,340	144,717	0			2.00
3.00	CT SCAN	57.00	273	26,492	0			3.00
4.00	MRI	58.00	3,475	47,185	0			4.00
	0		16,932	223,488				
	L - DIETARY TO CAFETERIA							
1.00	DIETARY	10.00	0	23,943	0			1.00
	0		0	23,943				
500.00	Grand Total: Decreases		52,338	3,561,708				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet 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	15,225	244,043	0	244,043	0	1.00	
2.00	Land Improvements	132,464	421,916	0	421,916	0	2.00	
3.00	Buildings and Fixtures	5,939,972	9,803,979	0	9,803,979	0	3.00	
4.00	Building Improvements	15,362,104	224,000	0	224,000	0	4.00	
5.00	Fixed Equipment	4,450,987	260,935	0	260,935	0	5.00	
6.00	Movable Equipment	17,227,927	0	0	0	4,912,737	6.00	
7.00	HIT designated Assets	4,823,956	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	47,952,635	10,954,873	0	10,954,873	4,912,737	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	47,952,635	10,954,873	0	10,954,873	4,912,737	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	259,268	0					1.00
2.00	Land Improvements	554,380	0					
3.00	Buildings and Fixtures	15,743,951	0					
4.00	Building Improvements	15,586,104	0					4.00
5.00	Fixed Equipment	4,711,922	0					
6.00	Movable Equipment	12,315,190	0					
7.00	HIT designated Assets	4,823,956	0					7.00
8.00	Subtotal (sum of lines 1-7)	53,994,771	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	53,994,771	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet 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	175,708	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	96,208	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	271,916	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	175,708				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	96,208				2.00
3.00	Total (sum of lines 1-2)	0	271,916				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet 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	32,143,703	0	32,143,703	0.595311	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,851,068	0	21,851,068	0.404689	0	2.00
3.00	Total (sum of lines 1-2)	53,994,771	0	53,994,771	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	175,708	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	96,208	125,650	2.00
3.00	Total (sum of lines 1-2)	0	0	0	271,916	125,650	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	0	187,989	64,461	-391,810	36,348	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	340	0	0	222,198	2.00
3.00	Total (sum of lines 1-2)	0	188,329	64,461	-391,810	258,546	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

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	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-10,534	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,004,101			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-338,398	CAP REL COSTS-BLDG & FIXT	1.00	14	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	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-99	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	B	-3,249	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		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	LOBBYING EXPENSES	A	-786	ADMINISTRATIVE & GENERAL	5.00	0	33.00

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ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
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			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	
36.00 OTHER MISCELLANEOUS REVENUE	B	-2,384	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 DEPRECIATION - ADMIN AND GENERAL	A	0	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 PATIENT PHONE WAGE COST	A	-2,011	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00 PATIENT PHONES BENEFITS COST	A	-512	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00 PATIENT PHONES DEPRECIATION COST	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00 PATIENT TV CABLE EXPENSE	A	0	OPERATION OF PLANT	7.00	0	42.00
43.00 MARKETING EXP - EXCL MARKETING DEPT	A	-4,188	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00 ILLINOIS PROVIDER TAX	A	-303,732	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 PHYSICIAN RECRUITING	A	-4,960	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00 LOBBYING EXPENSE IN ASSOCIATION DUES	A	-4,529	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00 CHARITABLE CONTRIBUTIONS	A	-40	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.01 MINORITY INTEREST	A	-53,412	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02 NONALLOWABLE LEGAL FEES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	49.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,732,935				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	732,669	732,669	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	914,361	914,361	0	0	0	2.00
3.00	60.00	LABORATORY	45,000	45,000	0	0	0	3.00
4.00	91.00	EMERGENCY	312,071	312,071	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,004,101	2,004,101	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	732,669		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	914,361		2.00
3.00	60.00	LABORATORY	0	0	0	45,000		3.00
4.00	91.00	EMERGENCY	0	0	0	312,071		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,004,101		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	36,348	36,348			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	222,198		222,198		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	661,395	127	777	662,299	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,267,919	4,748	29,027	75,338	5.00
7.00	00700	OPERATION OF PLANT	940,703	10,795	65,977	16,219	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,681	269	1,645	0	8.00
9.00	00900	HOUSEKEEPING	162,095	387	2,363	17,127	9.00
10.00	01000	DIETARY	817,047	983	6,011	0	10.00
11.00	01100	CAFETERIA	23,943	479	2,929	0	11.00
13.00	01300	NURSING ADMINISTRATION	132,551	534	3,266	63,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	296,528	1,052	6,433	3,030	14.00
15.00	01500	PHARMACY	141,414	388	2,371	25,380	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	145,729	1,077	6,584	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	228,371	3,753	22,943	87,314	30.00
31.00	03100	INTENSIVE CARE UNIT	343,552	613	3,748	70,299	31.00
40.00	04000	SUBPROVIDER - IPF	198,897	1,122	6,857	99,833	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	490,886	2,179	13,323	22,421	50.00
51.00	05100	RECOVERY ROOM	-1	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,608	49	299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	629,872	1,469	8,978	57,657	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	1,296,168	954	5,832	52,145	60.00
65.00	06500	RESPIRATORY THERAPY	60,908	376	2,300	726	65.00
66.00	06600	PHYSICAL THERAPY	384,268	451	2,759	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	159,454	941	5,750	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	787,570	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	709,777	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	335,682	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	128,667	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	472,785	592	3,621	4,137	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	196,585	711	4,349	61,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,396,600	34,049	208,142	656,072	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,459	334	2,044	119	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	46,282	106	649	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	44,772	0	0	6,108	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	1,859	11,363	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	12,490,113	36,348	222,198	662,299	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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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	2,377,032					5.00
7.00	00700	OPERATION OF PLANT	242,965	1,276,659				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,409	16,613	139,617			8.00
9.00	00900	HOUSEKEEPING	42,772	23,867	0	248,611		9.00
10.00	01000	DIETARY	193,687	60,706	0	13,458	1,091,892	10.00
11.00	01100	CAFETERIA	6,429	29,577	0	6,557	0	11.00
13.00	01300	NURSING ADMINISTRATION	46,956	32,978	0	7,311	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,169	64,968	0	14,403	0	14.00
15.00	01500	PHARMACY	39,853	23,945	0	5,308	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,054	66,493	0	14,741	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	80,475	231,702	39,641	51,368	383,018	30.00
31.00	03100	INTENSIVE CARE UNIT	98,299	37,848	10,110	8,390	85,230	31.00
40.00	04000	SUBPROVIDER - IPF	72,090	69,245	22,834	15,351	623,644	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	124,294	134,545	12,709	29,827	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	6,571	3,020	0	670	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	164,056	90,664	14,065	20,099	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	318,509	58,899	902	13,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,116	23,232	1,449	5,150	0	65.00
66.00	06600	PHYSICAL THERAPY	91,075	27,862	0	6,177	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,052	58,067	2,027	12,873	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,114	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	166,830	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,900	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	30,243	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	257	0	0	76.01
76.03	03950	WOUND CARE	113,088	36,563	5,092	8,106	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	61,738	43,917	27,937	9,736	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,349,744	1,134,711	137,023	242,582	1,091,892	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,165	20,642	0	4,576	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	11,056	6,556	2,594	1,453	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	11,959	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	3,108	114,750	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,377,032	1,276,659	139,617	248,611	1,091,892	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 9:26 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	69,914					11.00
13.00	01300	NURSING ADMINISTRATION	5,477	292,498				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	652	0	459,235			14.00
15.00	01500	PHARMACY	2,178	0	2,559	243,396		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6,264	0	276,942	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,883	79,505	12,385	0	13,410	30.00
31.00	03100	INTENSIVE CARE UNIT	8,931	53,033	8,542	0	5,224	31.00
40.00	04000	SUBPROVIDER - IPF	14,358	88,111	5,295	0	14,512	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,016	20,589	63,174	0	51,192	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	4,276	0	14,404	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,576	0	21,215	0	47,271	54.00
54.01	05401	ULTRASOUND	277	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	636	0	0	0	6	56.00
57.00	05700	CT SCAN	28	0	0	0	0	57.00
58.00	05800	MRI	347	0	0	0	0	58.00
60.00	06000	LABORATORY	6,787	0	64,293	0	58,036	60.00
65.00	06500	RESPIRATORY THERAPY	198	0	7,187	0	3,727	65.00
66.00	06600	PHYSICAL THERAPY	0	0	80	0	2,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	11,054	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	77	0	4,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	128,475	0	10,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	112,483	243,396	6,306	73.00
74.00	07400	RENAL DIALYSIS	0	0	63	0	613	74.00
76.00	03560	OTHER ANCILLARY COSTS	415	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	3,534	6,275	0	5,968	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,943	47,726	16,477	0	28,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	189	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,891	292,498	459,120	243,396	276,942	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	23	0	12	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	103	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	69,914	292,498	459,235	243,396	276,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,245,768	0	1,245,768	30.00
31.00	03100	INTENSIVE CARE UNIT	733,819	0	733,819	31.00
40.00	04000	SUBPROVIDER - IPF	1,232,149	0	1,232,149	40.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	970,155	0	970,155	50.00
51.00	05100	RECOVERY ROOM	-1	0	-1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	56,897	0	56,897	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,060,922	0	1,060,922	54.00
54.01	05401	ULTRASOUND	277	0	277	54.01
56.00	05600	RADIOISOTOPE	642	0	642	56.00
57.00	05700	CT SCAN	28	0	28	57.00
58.00	05800	MRI	347	0	347	58.00
60.00	06000	LABORATORY	1,875,582	0	1,875,582	60.00
65.00	06500	RESPIRATORY THERAPY	120,369	0	120,369	65.00
66.00	06600	PHYSICAL THERAPY	515,126	0	515,126	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	289,218	0	289,218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	976,929	0	976,929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,015,472	0	1,015,472	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,767	0	776,767	73.00
74.00	07400	RENAL DIALYSIS	159,586	0	159,586	74.00
76.00	03560	OTHER ANCILLARY COSTS	415	0	415	76.00
76.01	03610	SLEEP LAB	257	0	257	76.01
76.03	03950	WOUND CARE	659,761	0	659,761	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	505,347	0	505,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	189	0	189	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,196,021	0	12,196,021	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	31,374	0	31,374	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	68,696	0	68,696	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	MARKETING	62,942	0	62,942	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	194.02
194.03	07953	UNUSED SPACE	131,080	0	131,080	194.03
194.04	07954	GUEST MEALS	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,490,113	0	12,490,113	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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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	127	777	904	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,748	29,027	33,775	5.00
7.00	00700	OPERATION OF PLANT	0	10,795	65,977	76,772	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	269	1,645	1,914	8.00
9.00	00900	HOUSEKEEPING	0	387	2,363	2,750	9.00
10.00	01000	DIETARY	0	983	6,011	6,994	10.00
11.00	01100	CAFETERIA	0	479	2,929	3,408	11.00
13.00	01300	NURSING ADMINISTRATION	0	534	3,266	3,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,052	6,433	7,485	14.00
15.00	01500	PHARMACY	0	388	2,371	2,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,077	6,584	7,661	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,753	22,943	26,696	30.00
31.00	03100	INTENSIVE CARE UNIT	0	613	3,748	4,361	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,122	6,857	7,979	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,179	13,323	15,502	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	49	299	348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,469	8,978	10,447	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	954	5,832	6,786	60.00
65.00	06500	RESPIRATORY THERAPY	0	376	2,300	2,676	65.00
66.00	06600	PHYSICAL THERAPY	0	451	2,759	3,210	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	941	5,750	6,691	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	592	3,621	4,213	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	711	4,349	5,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	34,049	208,142	242,191	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	334	2,044	2,378	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	106	649	755	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	1,859	11,363	13,222	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	36,348	222,198	258,546	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
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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	33,878					5.00
7.00	00700	OPERATION OF PLANT	3,463	80,257				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	334	1,044	3,292			8.00
9.00	00900	HOUSEKEEPING	610	1,500	0	4,883		9.00
10.00	01000	DIETARY	2,761	3,816	0	264	13,835	10.00
11.00	01100	CAFETERIA	92	1,859	0	129	0	11.00
13.00	01300	NURSING ADMINISTRATION	669	2,073	0	144	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,029	4,084	0	283	0	14.00
15.00	01500	PHARMACY	568	1,505	0	104	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	514	4,180	0	290	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,147	14,567	935	1,008	4,853	30.00
31.00	03100	INTENSIVE CARE UNIT	1,401	2,379	238	165	1,080	31.00
40.00	04000	SUBPROVIDER - IPF	1,027	4,353	538	302	7,902	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,772	8,458	300	586	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	94	190	0	13	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,338	5,700	332	395	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,536	3,703	21	256	0	60.00
65.00	06500	RESPIRATORY THERAPY	215	1,460	34	101	0	65.00
66.00	06600	PHYSICAL THERAPY	1,298	1,752	0	121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	557	3,650	48	253	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,638	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,378	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,125	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	431	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	6	0	0	76.01
76.03	03950	WOUND CARE	1,612	2,299	120	159	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	880	2,761	659	191	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,489	71,333	3,231	4,764	13,835	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	17	1,298	0	90	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	158	412	61	29	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	170	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	44	7,214	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	33,878	80,257	3,292	4,883	13,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 9:26 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	5,488					11.00
13.00	01300	NURSING ADMINISTRATION	430	7,203				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51	0	12,936			14.00
15.00	01500	PHARMACY	171	0	72	5,214		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	176	0	12,821	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	933	1,958	349	0	621	30.00
31.00	03100	INTENSIVE CARE UNIT	701	1,306	241	0	242	31.00
40.00	04000	SUBPROVIDER - IPF	1,125	2,170	149	0	672	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	394	507	1,780	0	2,371	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	120	0	667	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	438	0	598	0	2,189	54.00
54.01	05401	ULTRASOUND	22	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	50	0	0	0	0	56.00
57.00	05700	CT SCAN	2	0	0	0	0	57.00
58.00	05800	MRI	27	0	0	0	0	58.00
60.00	06000	LABORATORY	533	0	1,811	0	2,684	60.00
65.00	06500	RESPIRATORY THERAPY	16	0	202	0	173	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2	0	114	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2	0	193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,620	0	481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,168	5,214	292	73.00
74.00	07400	RENAL DIALYSIS	0	0	2	0	28	74.00
76.00	03560	OTHER ANCILLARY COSTS	33	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	87	177	0	276	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	545	1,175	464	0	1,306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	15	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,486	7,203	12,933	5,214	12,821	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	3	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	5,488	7,203	12,936	5,214	12,821	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,186	0	53,186	30.00
31.00	03100	INTENSIVE CARE UNIT	12,210	0	12,210	31.00
40.00	04000	SUBPROVIDER - IPF	26,353	0	26,353	40.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,701	0	31,701	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,432	0	1,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,516	0	22,516	54.00
54.01	05401	ULTRASOUND	22	0	22	54.01
56.00	05600	RADIOISOTOPE	50	0	50	56.00
57.00	05700	CT SCAN	2	0	2	57.00
58.00	05800	MRI	27	0	27	58.00
60.00	06000	LABORATORY	20,401	0	20,401	60.00
65.00	06500	RESPIRATORY THERAPY	4,878	0	4,878	65.00
66.00	06600	PHYSICAL THERAPY	6,497	0	6,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,711	0	11,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,833	0	2,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,479	0	6,479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,799	0	9,799	73.00
74.00	07400	RENAL DIALYSIS	461	0	461	74.00
76.00	03560	OTHER ANCILLARY COSTS	33	0	33	76.00
76.01	03610	SLEEP LAB	6	0	6	76.01
76.03	03950	WOUND CARE	8,949	0	8,949	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,124	0	13,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	15	0	15	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	232,685	0	232,685	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,785	0	3,785	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,415	0	1,415	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	MARKETING	181	0	181	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	194.02
194.03	07953	UNUSED SPACE	20,480	0	20,480	194.03
194.04	07954	GUEST MEALS	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	258,546	0	258,546	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 9:26 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	317,967				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		317,967			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,112	1,112	747,767		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,538	41,538	85,060	-2,377,032	5.00
7.00	00700	OPERATION OF PLANT	94,415	94,415	18,312	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	19,337	0	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	71,610	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	9,206	3,421	0	14.00
15.00	01500	PHARMACY	3,393	3,393	28,655	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,832	32,832	98,582	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	79,371	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	9,812	112,717	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,065	19,065	25,314	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	428	428	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	12,847	65,097	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	8,346	58,874	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	3,292	820	0	65.00
66.00	06600	PHYSICAL THERAPY	3,948	3,948	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,228	8,228	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,181	5,181	4,671	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,223	6,223	68,896	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,853	297,853	740,737	-2,377,031	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,925	2,925	134	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	929	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	6,896	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	16,260	16,260	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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)	36,348	222,198	662,299	2,377,032	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.114314	0.698808	0.885702	0.235045	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			904	33,878	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001209	0.003350	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 9:26 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	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		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	180,902				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	223,474			8.00
9.00	00900	HOUSEKEEPING	3,382	0	158,906		9.00
10.00	01000	DIETARY	8,602	0	8,602	23,342	10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,206	0	9,206	0	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,832	63,452	32,832	8,188	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	16,182	5,363	1,822	31.00
40.00	04000	SUBPROVIDER - IPF	9,812	36,548	9,812	13,332	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,065	20,342	19,065	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	428	0	428	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,847	22,512	12,847	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,346	1,443	8,346	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,292	2,319	3,292	0	65.00
66.00	06600	PHYSICAL THERAPY	3,948	0	3,948	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,228	3,245	8,228	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	412	0	0	76.01
76.03	03950	WOUND CARE	5,181	8,151	5,181	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,223	44,716	6,223	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,788	219,322	155,052	23,342	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,925	0	2,925	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	929	4,152	929	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	16,260	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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)	1,276,659	139,617	248,611	1,091,892	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.057186	0.624757	1.564516	46.777997	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,257	3,292	4,883	13,835	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.443649	0.014731	0.030729	0.592708	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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					11.00
13.00	01300	NURSING ADMINISTRATION	308,845				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,853,751			14.00
15.00	01500	PHARMACY	0	15,905	351,586		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,924	0	261,656,548	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	83,948	76,961	0	12,674,480	30.00
31.00	03100	INTENSIVE CARE UNIT	55,997	53,079	0	4,937,275	31.00
40.00	04000	SUBPROVIDER - IPF	93,035	32,902	0	13,716,078	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,740	392,575	0	48,385,884	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	26,569	0	13,613,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	131,835	0	44,679,594	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,428	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	399,529	0	54,752,319	60.00
65.00	06500	RESPIRATORY THERAPY	0	44,662	0	3,523,002	65.00
66.00	06600	PHYSICAL THERAPY	0	497	0	2,319,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,447,762	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	476	0	3,939,119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	798,364	0	9,820,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	698,984	351,586	5,959,908	73.00
74.00	07400	RENAL DIALYSIS	0	390	0	579,804	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	3,732	38,994	0	5,641,170	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	50,393	102,389	0	26,660,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	308,845	2,853,035	351,586	261,656,548	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	73	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	MARKETING	0	643	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	194.04
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)	292,498	459,235	243,396	276,942	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.947071	0.160923	0.692280	0.001058	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,203	12,936	5,214	12,821	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.023322	0.004533	0.014830	0.000049	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

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Part I
Date/Time Prepared:
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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:26 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	9,697,997		9,697,997			30.00
31.00	03100	INTENSIVE CARE UNIT	4,937,275		4,937,275			31.00
40.00	04000	SUBPROVIDER - IPF	13,716,078		13,716,078			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,156,256	41,229,628	48,385,884	0.020050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,419,569	11,194,372	13,613,941	0.004179	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,329,798	38,349,796	44,679,594	0.023745	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	5,428	0	5,428	0.118276	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	10,332,506	44,419,813	54,752,319	0.034256	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,327,686	1,195,316	3,523,002	0.034167	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,082,346	236,915	2,319,261	0.222108	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,964,008	8,483,754	10,447,762	0.027682	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,423,582	1,515,537	3,939,119	0.248007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,889,872	6,930,928	9,820,800	0.103400	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,903,551	3,056,357	5,959,908	0.130332	0.000000	73.00
74.00	07400	RENAL DIALYSIS	543,012	36,792	579,804	0.275241	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	20,546	5,620,624	5,641,170	0.116955	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,949,415	22,711,308	26,660,723	0.018955	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	910,506	2,065,977	2,976,483	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	74,609,431	187,047,117	261,656,548			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,609,431	187,047,117	261,656,548			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.020050		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.004179		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.023745		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.118276		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.034256		60.00
65.00	06500	RESPIRATORY THERAPY	0.034167		65.00
66.00	06600	PHYSICAL THERAPY	0.222108		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.027682		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.248007		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103400		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130332		73.00
74.00	07400	RENAL DIALYSIS	0.275241		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.116955		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.018955		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:26 am

				Title XIX		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	1,245,768		1,245,768	0	1,245,768	30.00	
31.00	03100	INTENSIVE CARE UNIT	733,819		733,819	0	733,819	31.00	
40.00	04000	SUBPROVIDER - IPF	1,232,149		1,232,149	0	1,232,149	40.00	
43.00	04300	NURSERY	0		0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	970,155		970,155	0	970,155	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	56,897		56,897	0	56,897	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,060,922		1,060,922	0	1,060,922	54.00	
54.01	05401	ULTRASOUND	277		277	0	277	54.01	
56.00	05600	RADIOISOTOPE	642		642	0	642	56.00	
57.00	05700	CT SCAN	28		28	0	28	57.00	
58.00	05800	MRI	347		347	0	347	58.00	
60.00	06000	LABORATORY	1,875,582		1,875,582	0	1,875,582	60.00	
65.00	06500	RESPIRATORY THERAPY	120,369	0	120,369	0	120,369	65.00	
66.00	06600	PHYSICAL THERAPY	515,126	0	515,126	0	515,126	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	289,218		289,218	0	289,218	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	976,929		976,929	0	976,929	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,015,472		1,015,472	0	1,015,472	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	776,767		776,767	0	776,767	73.00	
74.00	07400	RENAL DIALYSIS	159,586		159,586	0	159,586	74.00	
76.00	03560	OTHER ANCILLARY COSTS	415		415	0	415	76.00	
76.01	03610	SLEEP LAB	257		257	0	257	76.01	
76.03	03950	WOUND CARE	659,761		659,761	0	659,761	76.03	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	505,347		505,347	0	505,347	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	189		189	0	189	95.00	
200.00		Subtotal (see instructions)	12,196,022	0	12,196,022	0	12,196,022	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	12,196,022	0	12,196,022	0	12,196,022	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:26 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	9,697,997		9,697,997			30.00
31.00	03100	INTENSIVE CARE UNIT	4,937,275		4,937,275			31.00
40.00	04000	SUBPROVIDER - IPF	13,716,078		13,716,078			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,156,256	41,229,628	48,385,884	0.020050	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,419,569	11,194,372	13,613,941	0.004179	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,329,798	38,349,796	44,679,594	0.023745	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	5,428	0	5,428	0.118276	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	10,332,506	44,419,813	54,752,319	0.034256	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,327,686	1,195,316	3,523,002	0.034167	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,082,346	236,915	2,319,261	0.222108	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,964,008	8,483,754	10,447,762	0.027682	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,423,582	1,515,537	3,939,119	0.248007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,889,872	6,930,928	9,820,800	0.103400	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,903,551	3,056,357	5,959,908	0.130332	0.000000	73.00
74.00	07400	RENAL DIALYSIS	543,012	36,792	579,804	0.275241	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	20,546	5,620,624	5,641,170	0.116955	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,949,415	22,711,308	26,660,723	0.018955	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	910,506	2,065,977	2,976,483	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	74,609,431	187,047,117	261,656,548			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,609,431	187,047,117	261,656,548			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.020050		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.004179		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.023745		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.118276		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.034256		60.00
65.00	06500	RESPIRATORY THERAPY	0.034167		65.00
66.00	06600	PHYSICAL THERAPY	0.222108		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.027682		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.248007		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103400		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130332		73.00
74.00	07400	RENAL DIALYSIS	0.275241		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03950	WOUND CARE	0.116955		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.018955		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part II
Date/Time Prepared:
11/29/2021 9:26 am

			Title XIX		Hospital	PPS		
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	970,155	31,701	938,454	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	56,897	1,432	55,465	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,060,922	22,516	1,038,406	0	0	54.00
54.01	05401	ULTRASOUND	277	22	255	0	0	54.01
56.00	05600	RADIOISOTOPE	642	50	592	0	0	56.00
57.00	05700	CT SCAN	28	2	26	0	0	57.00
58.00	05800	MRI	347	27	320	0	0	58.00
60.00	06000	LABORATORY	1,875,582	20,401	1,855,181	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	120,369	4,878	115,491	0	0	65.00
66.00	06600	PHYSICAL THERAPY	515,126	6,497	508,629	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	289,218	11,711	277,507	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	976,929	2,833	974,096	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,015,472	6,479	1,008,993	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,767	9,799	766,968	0	0	73.00
74.00	07400	RENAL DIALYSIS	159,586	461	159,125	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	415	33	382	0	0	76.00
76.01	03610	SLEEP LAB	257	6	251	0	0	76.01
76.03	03950	WOUND CARE	659,761	8,949	650,812	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	505,347	13,124	492,223	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	189	15	174	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	8,984,286	140,936	8,843,350	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	8,984,286	140,936	8,843,350	0	0	202.00

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

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part II
Date/Time Prepared:
11/29/2021 9:26 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	970,155	48,385,884	0.020050		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	56,897	13,613,941	0.004179		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,060,922	44,679,594	0.023745		54.00
54.01	05401	ULTRASOUND	277	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	642	5,428	0.118276		56.00
57.00	05700	CT SCAN	28	0	0.000000		57.00
58.00	05800	MRI	347	0	0.000000		58.00
60.00	06000	LABORATORY	1,875,582	54,752,319	0.034256		60.00
65.00	06500	RESPIRATORY THERAPY	120,369	3,523,002	0.034167		65.00
66.00	06600	PHYSICAL THERAPY	515,126	2,319,261	0.222108		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	289,218	10,447,762	0.027682		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	976,929	3,939,119	0.248007		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,015,472	9,820,800	0.103400		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776,767	5,959,908	0.130332		73.00
74.00	07400	RENAL DIALYSIS	159,586	579,804	0.275241		74.00
76.00	03560	OTHER ANCILLARY COSTS	415	0	0.000000		76.00
76.01	03610	SLEEP LAB	257	0	0.000000		76.01
76.03	03950	WOUND CARE	659,761	5,641,170	0.116955		76.03
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	505,347	26,660,723	0.018955		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,976,483	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	189	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	8,984,286	233,305,198			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	8,984,286	233,305,198			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 9:26 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	53,186	0	53,186	2,647	20.09	30.00	
31.00	INTENSIVE CARE UNIT	12,210		12,210	589	20.73	31.00	
40.00	SUBPROVIDER - IPF	26,353	0	26,353	4,310	6.11	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	91,749		91,749	7,546		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	1,361	27,342					30.00
31.00	INTENSIVE CARE UNIT	341	7,069					31.00
40.00	SUBPROVIDER - IPF	2,427	14,829					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	4,129	49,240					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 9:26 am

			Title XVIII		Hospital	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	31,701	48,385,884	0.000655	3,724,926	2,440
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	1,432	13,613,941	0.000105	1,243,431	131
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,516	44,679,594	0.000504	3,012,009	1,518
54.01	05401	ULTRASOUND	22	0	0.000000	0	0
56.00	05600	RADIOISOTOPE	50	5,428	0.009211	0	0
57.00	05700	CT SCAN	2	0	0.000000	0	0
58.00	05800	MRI	27	0	0.000000	0	0
60.00	06000	LABORATORY	20,401	54,752,319	0.000373	4,503,335	1,680
65.00	06500	RESPIRATORY THERAPY	4,878	3,523,002	0.001385	1,126,369	1,560
66.00	06600	PHYSICAL THERAPY	6,497	2,319,261	0.002801	862,882	2,417
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	11,711	10,447,762	0.001121	1,058,749	1,187
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,833	3,939,119	0.000719	1,440,488	1,036
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,479	9,820,800	0.000660	1,428,422	943
73.00	07300	DRUGS CHARGED TO PATIENTS	9,799	5,959,908	0.001644	971,473	1,597
74.00	07400	RENAL DIALYSIS	461	579,804	0.000795	300,492	239
76.00	03560	OTHER ANCILLARY COSTS	33	0	0.000000	0	0
76.01	03610	SLEEP LAB	6	0	0.000000	0	0
76.03	03950	WOUND CARE	8,949	5,641,170	0.001586	20,546	33
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,124	26,660,723	0.000492	1,843,262	907
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,976,483	0.000000	381,073	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	140,921	233,305,198		21,917,457	15,688

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0040		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 9:26 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	2,647	0.00	1,361	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	589	0.00	341	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,310	0.00	2,427	40.00		
43.00	04300	NURSERY	0	0	0	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)	0	0	7,546		4,129	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
40.00	04000	SUBPROVIDER - IPF	0							40.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	0							44.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:26 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:26 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	48,385,884	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,613,941	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,679,594	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,428	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	54,752,319	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,523,002	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,319,261	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,447,762	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,939,119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,820,800	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,959,908	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	579,804	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	5,641,170	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	26,660,723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,976,483	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	233,305,198		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	3,724,926	0	11,220,467	0
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	1,243,431	0	2,774,884	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,012,009	0	8,655,038	0
54.01	05401	ULTRASOUND	0.000000	0	0	0	0
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0
57.00	05700	CT SCAN	0.000000	0	0	0	0
58.00	05800	MRI	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.000000	4,503,335	0	2,535,752	0
65.00	06500	RESPIRATORY THERAPY	0.000000	1,126,369	0	244,204	0
66.00	06600	PHYSICAL THERAPY	0.000000	862,882	0	56,975	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,058,749	0	2,764,818	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,440,488	0	323,661	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,428,422	0	3,189,326	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	971,473	0	1,083,435	0
74.00	07400	RENAL DIALYSIS	0.000000	300,492	0	15,768	0
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0
76.01	03610	SLEEP LAB	0.000000	0	0	0	0
76.03	03950	WOUND CARE	0.000000	20,546	0	2,409,285	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	1,843,262	0	3,825,586	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	381,073	0	614,201	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)		21,917,457	0	39,713,400	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 9:26 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	0.020050	11,220,467	0	0	224,970	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	0.004179	2,774,884	0	0	11,596	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.023745	8,655,038	0	0	205,514	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.118276	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.034256	2,535,752	0	0	86,865	60.00
65.00	06500	RESPIRATORY THERAPY	0.034167	244,204	0	0	8,344	65.00
66.00	06600	PHYSICAL THERAPY	0.222108	56,975	0	0	12,655	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027682	2,764,818	0	0	76,536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.248007	323,661	0	0	80,270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103400	3,189,326	0	0	329,776	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130332	1,083,435	0	3,446	141,206	73.00
74.00	07400	RENAL DIALYSIS	0.275241	15,768	0	0	4,340	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.116955	2,409,285	0	0	281,778	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.018955	3,825,586	0	0	72,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	614,201	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		39,713,400	0	3,446	1,536,364	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		39,713,400	0	3,446	1,536,364	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 9:26 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
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	449	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.03	03950	WOUND CARE	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	449	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	449	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:

Worksheet D

Component CCN: 14-S040

From 05/01/2020

Part II

To 04/30/2021

Date/Time Prepared:

11/29/2021 9:26 am

Title XVIII

Subprovider -

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	31,701	48,385,884	0.000655	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1,432	13,613,941	0.000105	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,516	44,679,594	0.000504	384,947	194 54.00
54.01	05401	ULTRASOUND	22	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	50	5,428	0.009211	5,428	50 56.00
57.00	05700	CT SCAN	2	0	0.000000	0	57.00
58.00	05800	MRI	27	0	0.000000	0	58.00
60.00	06000	LABORATORY	20,401	54,752,319	0.000373	1,227,350	458 60.00
65.00	06500	RESPIRATORY THERAPY	4,878	3,523,002	0.001385	248,706	344 65.00
66.00	06600	PHYSICAL THERAPY	6,497	2,319,261	0.002801	362,907	1,017 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,711	10,447,762	0.001121	94,544	106 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,833	3,939,119	0.000719	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,479	9,820,800	0.000660	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,799	5,959,908	0.001644	636,396	1,046 73.00
74.00	07400	RENAL DIALYSIS	461	579,804	0.000795	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	33	0	0.000000	0	76.00
76.01	03610	SLEEP LAB	6	0	0.000000	0	76.01
76.03	03950	WOUND CARE	8,949	5,641,170	0.001586	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,124	26,660,723	0.000492	183,903	90 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,976,483	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	140,921	233,305,198		3,144,181	3,305 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 9:26 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
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
54.01	05401	ULTRASOUND		0	0	0	0	0	54.01
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	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
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: 14-0040 Component CCN: 14-S040		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 9:26 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	48,385,884	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,613,941	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,679,594	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,428	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	54,752,319	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,523,002	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,319,261	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,447,762	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,939,119	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,820,800	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,959,908	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	579,804	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	5,641,170	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	26,660,723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,976,483	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	233,305,198		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0040 Component CCN: 14-S040		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 9:26 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	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	384,947	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	5,428	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,227,350	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	248,706	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	362,907	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	94,544	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	636,396	0	0	522	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000	183,903	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			3,144,181	0	522	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:

Worksheet D

Component CCN: 14-S040

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
11/29/2021 9:26 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.020050	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	0.004179	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.023745	0	0	0	0 54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0 54.01
56.00	05600 RADIOISOTOPE	0.118276	0	0	0	0 56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800 MRI	0.000000	0	0	0	0 58.00
60.00	06000 LABORATORY	0.034256	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.034167	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.222108	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.027682	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.248007	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.103400	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130332	522	0	776	68 73.00
74.00	07400 RENAL DIALYSIS	0.275241	0	0	0	0 74.00
76.00	03560 OTHER ANCILLARY COSTS	0.000000	0	0	0	0 76.00
76.01	03610 SLEEP LAB	0.000000	0	0	0	0 76.01
76.03	03950 WOUND CARE	0.116955	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.018955	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00	Subtotal (see instructions)		522	0	776	68 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		522	0	776	68 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0040

Period:

Worksheet D

Component CCN: 14-S040

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
11/29/2021 9:26 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
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
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	101		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03950	WOUND CARE	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	101		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	101		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
Title XIX		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	53,186	0	53,186	2,647	20.09	30.00
31.00	INTENSIVE CARE UNIT	12,210		12,210	589	20.73	31.00
40.00	SUBPROVIDER - IPF	26,353	0	26,353	4,310	6.11	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	91,749		91,749	7,546		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	35	703				30.00
31.00	INTENSIVE CARE UNIT	88	1,824				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	123	2,527				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 9:26 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	31,701	48,385,884	0.000655	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1,432	13,613,941	0.000105	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,516	44,679,594	0.000504	0	54.00
54.01	05401	ULTRASOUND	22	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	50	5,428	0.009211	0	56.00
57.00	05700	CT SCAN	2	0	0.000000	0	57.00
58.00	05800	MRI	27	0	0.000000	0	58.00
60.00	06000	LABORATORY	20,401	54,752,319	0.000373	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,878	3,523,002	0.001385	0	65.00
66.00	06600	PHYSICAL THERAPY	6,497	2,319,261	0.002801	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,711	10,447,762	0.001121	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,833	3,939,119	0.000719	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,479	9,820,800	0.000660	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,799	5,959,908	0.001644	0	73.00
74.00	07400	RENAL DIALYSIS	461	579,804	0.000795	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	33	0	0.000000	0	76.00
76.01	03610	SLEEP LAB	6	0	0.000000	0	76.01
76.03	03950	WOUND CARE	8,949	5,641,170	0.001586	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,124	26,660,723	0.000492	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,976,483	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	140,921	233,305,198		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0040		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 9:26 am	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	2,647	0.00	35	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	589	0.00	88	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	4,310	0.00	0	40.00		
43.00	04300	NURSERY	0	0	0	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)	0	0	7,546		123	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
40.00	04000	SUBPROVIDER - IPF	0							40.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	0							44.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
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
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		Title XIX		Hospital		PPS	
		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	48,385,884	0.000000 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,613,941	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	44,679,594	0.000000 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000 54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,428	0.000000 56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000 57.00
58.00	05800	MRI	0	0	0	0	0.000000 58.00
60.00	06000	LABORATORY	0	0	0	54,752,319	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,523,002	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,319,261	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,447,762	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,939,119	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,820,800	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,959,908	0.000000 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	579,804	0.000000 74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0.000000 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0.000000 76.01
76.03	03950	WOUND CARE	0	0	0	5,641,170	0.000000 76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	26,660,723	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,976,483	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	233,305,198	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 9:26 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
54.01	05401	ULTRASOUND	0.000000	0	0	0	0 54.01
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	MRI	0.000000	0	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0 76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS							
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:26 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,647	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,647	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)		2,647	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)		1,361	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)		1,245,768	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)		1,245,768	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)		1,245,768	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)		470.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		640,527	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)		640,527	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 9:26 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	733,819	589	1,245.87	341	424,842
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)					1,316,727
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,382,096
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					34,411
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,688
52.00	Total Program excludable cost (sum of lines 50 and 51)					50,099
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,331,997
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

11/29/2021 9:26 am

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 9:26 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	53,186	1,245,768	0.042693	0	0	90.00
91.00 Nursing School cost	0	1,245,768	0.000000	0	0	91.00
92.00 Allied health cost	0	1,245,768	0.000000	0	0	92.00
93.00 All other Medical Education	0	1,245,768	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:26 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,310	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,310	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,310	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,427	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)		1,232,149	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)		1,232,149	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)		1,232,149	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)		285.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		693,831	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)		693,831	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1	
				Component CCN: 14-S040		Date/Time Prepared: 11/29/2021 9:26 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						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)					229,976	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					923,807	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)					14,829	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,305	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					18,134	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					905,673	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

11/29/2021 9:26 am

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:

Worksheet D-1

Component CCN: 14-S040

From 05/01/2020
To 04/30/2021Date/Time Prepared:
11/29/2021 9:26 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	26,353	1,232,149	0.021388	0	0	90.00
91.00	Nursing School cost	0	1,232,149	0.000000	0	0	91.00
92.00	Allied health cost	0	1,232,149	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,232,149	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 9:26 am
		Title XIX	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,647	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,647	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)		2,647	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)		35	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)		1,245,768	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)		1,245,768	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)		1,245,768	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)		470.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,472	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)		16,472	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	733,819	589	1,245.87	88	109,637
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					126,109
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,527
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,527
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					123,582
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 9:26 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	53,186	1,245,768	0.042693	0	90.00
91.00	Nursing School cost	0	1,245,768	0.000000	0	91.00
92.00	Allied health cost	0	1,245,768	0.000000	0	92.00
93.00	All other Medical Education	0	1,245,768	0.000000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 9:26 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		5,134,727	30.00
31.00	03100	INTENSIVE CARE UNIT		2,655,538	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	0.020050	3,724,926	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.004179	1,243,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.023745	3,012,009	54.00
54.01	05401	ULTRASOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.118276	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.034256	4,503,335	60.00
65.00	06500	RESPIRATORY THERAPY	0.034167	1,126,369	65.00
66.00	06600	PHYSICAL THERAPY	0.222108	862,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027682	1,058,749	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.248007	1,440,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.103400	1,428,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.130332	971,473	73.00
74.00	07400	RENAL DIALYSIS	0.275241	300,492	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	76.01
76.03	03950	WOUND CARE	0.116955	20,546	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.018955	1,843,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	381,073	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,917,457	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)		21,917,457	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 9:26 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		7,718,508		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.020050	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.004179	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.023745	384,947	9,141	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.118276	5,428	642	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.034256	1,227,350	42,044	60.00
65.00	06500 RESPIRATORY THERAPY	0.034167	248,706	8,498	65.00
66.00	06600 PHYSICAL THERAPY	0.222108	362,907	80,605	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.027682	94,544	2,617	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.248007	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.103400	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.130332	636,396	82,943	73.00
74.00	07400 RENAL DIALYSIS	0.275241	0	0	74.00
76.00	03560 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.000000	0	0	76.01
76.03	03950 WOUND CARE	0.116955	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.018955	183,903	3,486	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,144,181	229,976	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)		3,144,181		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E
Part A
Date/Time Prepared:
11/29/2021 9:26 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)			1,149,614	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,953,529	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)			7,362	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			83,196	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)			96.26	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)			4.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)			13.54	31.00
32.00	Sum of lines 30 and 31			17.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)			4.70	33.00
34.00	Disproportionate share adjustment (see instructions)			36,462	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 9:26 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	270,835	178,318		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	113,218	103,571		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	216,789			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	3,446,952			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	3,869,363			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			3,763,760	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			248,153	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			35,398	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			4,047,311	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			4,047,311	61.00
62.00	Deductibles billed to program beneficiaries			397,924	62.00
63.00	Coinsurance billed to program beneficiaries			18,047	63.00
64.00	Allowable bad debts (see instructions)			0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,631,340	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			-1,308	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-1,809	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-14,039	70.93
70.94	HRR adjustment amount (see instructions)			-18,353	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E
Part A
Date/Time Prepared:
11/29/2021 9:26 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)			3,595,831	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			3,741,678	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-145,847	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			4,746	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)		132,799	184,009	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.9996363764	0.9931515372	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		-48	-1,260	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9958	0.9932	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-558	-1,251	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

11/29/2021 9:26 am

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 9:26 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	1,149,614	0	1,149,614		1,149,614
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,953,529	0		1,953,529	1,953,529
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	7,362	0	7,362		7,362
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	83,196	0		83,196	83,196
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	0.0470	0.0470	0.0470	0.0470	
11.00	Disproportionate share adjustment (see instructions)	34.00	36,462	0	13,508	22,954	36,462
11.01	Uncompensated care payments	36.00	216,789	0	113,218	103,571	216,789
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	3,446,952	0	1,283,702	2,163,250	3,446,952
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,869,363	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,763,760	0	1,283,702	2,480,058	3,763,760
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	248,153	0	91,128	157,025	248,153

11/29/2021 9:26 am

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 9:26 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	35,398	0	0	35,398	35,398	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	1,374,830	2,672,481	4,047,311	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	232,236	0	90,175	142,061	232,236	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	15,917	0	953	14,964	15,917	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	248,153	0	91,128	157,025	248,153	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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 9:26 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	1,149,614	1,149,614		1,149,614	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,953,529		1,953,529	1,953,529	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	7,362	7,362		7,362	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	83,196		83,196	83,196	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	0.0470	0.0470	0.0470		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	36,462	13,508	22,954	36,462	11.00
11.01	Uncompensated care payments	36.00	216,789	113,218	103,571	216,789	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	3,446,952	1,283,702	2,163,250	3,446,952	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,869,363	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,763,760	1,283,702	2,480,058	3,763,760	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	248,153	91,128	157,025	248,153	16.00
17.00	Special add-on payments for new technologies	54.00	35,398	0	35,398	35,398	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			1,374,830	2,672,481	4,047,311	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 9:26 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	232,236	90,175	142,061	232,236	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	15,917	953	14,964	15,917	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	248,153	91,128	157,025	248,153	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	-14,039	-418	-13,621	-14,039	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-1,308	-48	-1,260	-1,308	30.01
31.00	HRR adjustment (see instructions)	70.94	-18,353	-4,828	-13,525	-18,353	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-1,809	-558	-1,251	-1,809	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: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 9:26 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		449	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,536,364	2.00
3.00	OPPS payments		3,008,175	3.00
4.00	Outlier payment (see instructions)		24,959	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)		449	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,446	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)		3,446	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)		3,446	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,997	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)		449	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)		3,033,134	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)		545,620	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,487,963	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,487,963	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,487,963	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,487,963	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,487,963	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,589,186	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)		-101,223	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

11/29/2021 9:26 am

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 9:26 am
		Component CCN: 14-S040		
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		101	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		68	2.00
3.00	OPPS payments		109	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)		101	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		776	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)		776	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)		776	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		675	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)		101	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)		109	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		210	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)		210	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		210	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)		210	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)		210	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		373	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)		-163	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

11/29/2021 9:26 am

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 9:26 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		3,741,678		2,589,186	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,741,678		2,589,186	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		145,847		101,223	6.02
7.00	Total Medicare program liability (see instructions)		3,595,831		2,487,963	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: 14-0040

Period:

Worksheet E-1

Component CCN: 14-S040

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
11/29/2021 9:26 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		2,267,001		373	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)		0		0	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)		2,267,001		373	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		163	6.02
7.00	Total Medicare program liability (see instructions)		2,267,001		210	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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/29/2021 9:26 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0040 Component CCN: 14-S040	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/29/2021 9:26 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,431,345	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 instnctions)		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 instnctions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		11.808219	9.00
10.00	Teaching Adjustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,431,345	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)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,431,345	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,431,345	18.00
19.00	Deductibles		99,928	19.00
20.00	Subtotal (line 18 minus line 19)		2,331,417	20.00
21.00	Coinsurance		64,416	21.00
22.00	Subtotal (line 20 minus line 21)		2,267,001	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,267,001	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
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,267,001	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		2,267,001	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)		0	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 9:26 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	Managed Care	Total	
		A			
		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)	4,129	1,107		26.00
27.00	Total Inpatient Days (see instructions)	7,546	7,546		27.00
28.00	Ratio of inpatient days to total inpatient days	0.547177	0.146700		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: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 9:26 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		579,804	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)		3,305,903	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)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		3,305,903	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		1,536,982	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		1,536,982	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		4,842,885	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.682631	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.317369	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: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet G

Date/Time Prepared:
11/29/2021 9:26 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	1,885,768	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	93,093,099	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,854,207	0	0	0	6.00
7.00	Inventory	1,405,610	0	0	0	7.00
8.00	Prepaid expenses	1,654,560	0	0	0	8.00
9.00	Other current assets	777,719	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)	95,962,549	0	0	0	11.00
FIXED ASSETS						
12.00	Land	259,268	0	0	0	12.00
13.00	Land improvements	554,380	0	0	0	13.00
14.00	Accumulated depreciation	-523,811	0	0	0	14.00
15.00	Buildings	15,743,951	0	0	0	15.00
16.00	Accumulated depreciation	-8,372,127	0	0	0	16.00
17.00	Leasehold improvements	15,586,104	0	0	0	17.00
18.00	Accumulated depreciation	-8,464,144	0	0	0	18.00
19.00	Fixed equipment	4,426,915	0	0	0	19.00
20.00	Accumulated depreciation	-2,758,546	0	0	0	20.00
21.00	Automobiles and trucks	30,160	0	0	0	21.00
22.00	Accumulated depreciation	-30,160	0	0	0	22.00
23.00	Major movable equipment	12,315,190	0	0	0	23.00
24.00	Accumulated depreciation	-10,697,883	0	0	0	24.00
25.00	Minor equipment depreciable	5,078,803	0	0	0	25.00
26.00	Accumulated depreciation	-4,765,800	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)	18,382,300	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,485,262	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,485,262	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	115,830,111	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	17,024,148	0	0	0	37.00
38.00	Salaries, wages, and fees payable	582,716	0	0	0	38.00
39.00	Payroll taxes payable	105,114	0	0	0	39.00
40.00	Notes and loans payable (short term)	26,137	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	-12,686,090	0	0	0	43.00
44.00	Other current liabilities	5,962,288	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,014,313	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,014,313	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	104,815,798				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	104,815,798	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	115,830,111	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-1

Date/Time Prepared:
11/29/2021 9:26 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		32,971,818		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		71,843,981				2.00
3.00	Total (sum of line 1 and line 2)		104,815,799		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		104,815,799		0		11.00
12.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		104,815,797		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		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	ROUNDING		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: 14-0040

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 9:26 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,697,997		9,697,997	1.00
2.00	SUBPROVIDER - IPF	13,716,078		13,716,078	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	0		0	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)	23,414,075		23,414,075	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,937,275		4,937,275	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)	4,937,275		4,937,275	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,351,350		28,351,350	17.00
18.00	Ancillary services	41,394,945	162,269,829	203,664,774	18.00
19.00	Outpatient services	4,863,136	24,777,285	29,640,421	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	74,609,431	187,047,114	261,656,545	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,223,048		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)		15,223,048		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0040

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-3

Date/Time Prepared:
11/29/2021 9:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	261,656,545	1.00
2.00	Less contractual allowances and discounts on patients' accounts	174,946,023	2.00
3.00	Net patient revenues (line 1 minus line 2)	86,710,522	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,223,048	4.00
5.00	Net income from service to patients (line 3 minus line 4)	71,487,474	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	356,507	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	356,507	25.00
26.00	Total (line 5 plus line 25)	71,843,981	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	71,843,981	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0040	Period: From 05/01/2020 To 04/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/29/2021 9:26 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		232,236	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		15,917	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)		8.87	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)		248,153	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