

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: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/25/2022 2:44 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF SAINT ANTHONYS HEALTH CENTER (14-0052) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	37,974	-60,602	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		77,110		0	10.00
200.00 Total	0	37,974	16,508	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: 14-0052		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 2:44 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 SAINT ANTHONYS WAY			PO Box:				1.00			
2.00	City: ALTON			State: IL		Zip Code: 62002-4568		County: MADISON			
		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		OSF SAINT ANTHONYS HEALTH CENTER		140052	41180	1	07/01/1966	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF		SAINT ANTHONYS COMPREHENSIVE REHAB		14T052	41180	5	01/01/1993	N	P	O
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		GODFREY CLINIC		148612	41180		07/17/2020	N	O	N
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)						10/01/2020		09/30/2021		20.00
21.00	Type of Control (see instructions)						1				21.00
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
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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.	199	291	0	0	1,196	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.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	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.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
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		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)					
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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)					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.					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)					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.					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)					76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 2:44 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	N	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.	N	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.	N	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.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 2:44 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	39,492	480,000	109,927118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1728	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0052		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/25/2022 2:44 pm		
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: OSF HEALTHCARE SYSTEM		Contractor's Name: WPS		Contractor's Number: 06101				141.00	
142.00	Street: 800 NE GLEN OAK AVENUE		PO Box:						142.00	
143.00	City: PEORIA		State: IL		Zip Code: 61603				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.				N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	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			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/25/2022 2:44 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/15/2022
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/15/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LOUIS	RAPTOPOULOS		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)-624-9230	LOUIS.C.RAPTOPOULOS@OSFHEALT CARE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STRATEGIC REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

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	38	13,870	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)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	11	4,015	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		49	17,885	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		49			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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

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)	3,448	179	9,953			1.00
2.00	HMO and other (see instructions)	2,715	1,487				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,448	179	9,953			7.00
8.00	INTENSIVE CARE UNIT	716	20	1,684			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)	4,164	199	11,637	0.00	374.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,948	3,679	22,978	0.00	33.33	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	408.10	27.00
28.00	Observation Bed Days		230	891			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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	944	57	2,338	1.00
2.00 HMO and other (see instructions)			620	351		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	944	57	2,338	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	27,123,479	37,226	27,160,705	850,550.00	31.93
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		16,147	0	16,147	319.00	50.62
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,758,555	71,658	2,830,213	70,615.00	40.08
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)		79,045	11,988	91,033	3,196.00	28.48
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,209,696	0	1,209,696	9,600.00	126.01
12.00	Contract labor: Top level management and other management and administrative services		3,412	0	3,412	38.00	89.79
13.00	Contract labor: Physician-Part A - Administrative		50,400	0	50,400	336.00	150.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,320,620	0	7,320,620	193,633.00	37.81
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)		7,472,347	0	7,472,347		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		29,462	0	29,462		
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		3,935	0	3,935		
24.00	Wage-related costs (RHC/FQHC)		763,948	0	763,948		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		2,684,410	0	2,684,410		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	616,665	-614,680	1,985	27.00	73.52	26.00
27.00	Administrative & General	5.00	1,792,142	241,328	2,033,470	58,635.00	34.68	27.00
28.00	Administrative & General under contract (see inst.)		557,933	0	557,933	3,854.00	144.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	964,805	13,023	977,828	40,963.00	23.87	30.00
31.00	Laundry & Linen Service	8.00	19,141	790	19,931	1,226.00	16.26	31.00
32.00	Housekeeping	9.00	841,916	23,404	865,320	53,592.00	16.15	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	556,732	22,221	578,953	29,815.00	19.42	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	217,658	-487	217,171	12,901.00	16.83	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,194,445	27,783	1,222,228	28,055.00	43.57	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	176,339	372	176,711	8,349.00	21.17	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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/25/2022 2:44 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	24,906,710	-34,432	24,872,278	783,470.00	31.75	1.00
2.00	Excluded area salaries (see instructions)	79,045	11,988	91,033	3,196.00	28.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24,827,665	-46,420	24,781,245	780,274.00	31.76	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,584,128	0	8,584,128	203,607.00	42.16	4.00
5.00	Subtotal wage-related costs (see inst.)	10,156,757	0	10,156,757	0.00	40.99	5.00
6.00	Total (sum of lines 3 thru 5)	43,568,550	-46,420	43,522,130	983,881.00	44.24	6.00
7.00	Total overhead cost (see instructions)	6,937,776	-286,246	6,651,530	237,417.00	28.02	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
2/25/2022 2:44 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,083,218	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)	849,694	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)	4,124,308	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)	0	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)	52,102	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	130,872	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,941,362	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	88,136	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,269,692	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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,209,696	8,269,692	1.00
2.00	Hospital	1,209,696	8,269,692	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0052 Component CCN: 14-8612		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/25/2022 2:44 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			6702 GODFREY RD			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			GODFREY IL 62035-2205			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00 18:00		08:00 19:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			MADISON				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00 7.00		8.00 9.00		10.00	
Facility hours of operations (1)									
11.00	CLINIC			19:00 08:00		19:00 08:00		19:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0052 Component CCN: 14-8612		Period: From 10/01/2020 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 2/25/2022 2:44 pm
					RHC I	Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	19:00	11.00

Health Financial Systems		OSF SAINT ANTHONYS HEALTH CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/25/2022 2:44 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.203031	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			9,279,736	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			73,026,193	6.00
7.00	Medicaid cost (line 1 times line 6)			14,826,581	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			5,546,845	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			5,546,845	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)	5,203,056	563,112	5,766,168	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,056,382	563,112	1,619,494	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,056,382	563,112	1,619,494	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,017,014	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			370,591	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			570,139	27.01
28.00	Non-Medicare bad debt expense (see instructions)			3,446,875	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			899,370	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,518,864	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,065,709	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,221,416	2,221,416	212,576	2,433,992	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,535,725	1,535,725	100,779	1,636,504	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	616,665	7,461,023	8,077,688	272,392	8,350,080	4.00
5.01	00540	NONPATIENT TELEPHONES	247,177	31,394	278,571	3,747	282,318	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	305,862	-37,343	268,519	645	269,164	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	1,239,103	22,010,827	23,249,930	-2,255,328	20,994,602	5.05
7.00	00700	OPERATION OF PLANT	964,805	4,244,537	5,209,342	-1,553,921	3,655,421	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,141	206,068	225,209	790	225,999	8.00
9.00	00900	HOUSEKEEPING	841,916	409,185	1,251,101	24,392	1,275,493	9.00
10.00	01000	DIETARY	556,732	307,224	863,956	22,221	886,177	10.00
11.00	01100	CAFETERIA	217,658	247,513	465,171	459	465,630	11.00
13.00	01300	NURSING ADMINISTRATION	1,194,445	188,222	1,382,667	28,435	1,411,102	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12	12	371,622	371,634	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	176,339	129,308	305,647	372	306,019	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	820,225	820,225	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,084,128	1,952,444	5,036,572	62,013	5,098,585	30.00
31.00	03100	INTENSIVE CARE UNIT	1,438,566	1,405,482	2,844,048	-8,082	2,835,966	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,424,257	3,368,884	5,793,141	-3,049,666	2,743,475	50.00
51.00	05100	RECOVERY ROOM	327,266	33,242	360,508	24,262	384,770	51.00
53.00	05300	ANESTHESIOLOGY	0	972,964	972,964	9,948	982,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,980,694	139,299	2,119,993	1,539,505	3,659,498	54.00
57.00	05700	CT SCAN	229,912	285,957	515,869	44,744	560,613	57.00
58.00	05800	MRI	105,929	27,618	133,547	25,883	159,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	396,156	671,237	1,067,393	-571,082	496,311	59.00
60.00	06000	LABORATORY	1,451,649	2,343,658	3,795,307	145,522	3,940,829	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	164,547	164,547	0	164,547	62.00
64.00	06400	INTRAVENOUS THERAPY	513,999	-139,328	374,671	52,756	427,427	64.00
65.00	06500	RESPIRATORY THERAPY	672,372	194,529	866,901	35,378	902,279	65.00
66.00	06600	PHYSICAL THERAPY	940,154	205,920	1,146,074	-28,263	1,117,811	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,231	1,395	245,626	57,512	303,138	67.00
68.00	06800	SPEECH PATHOLOGY	200,397	3,673	204,070	47,777	251,847	68.00
69.00	06900	ELECTROCARDIOLOGY	320,358	76,369	396,727	-46,323	350,404	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	104,115	263,322	367,437	16,683	384,120	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-24,428	-24,428	1,839,341	1,814,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,760,227	1,760,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	787,570	11,829,612	12,617,182	164,976	12,782,158	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	414,855	5,143	419,998	15,676	435,674	76.03
76.04	03952	PAIN CLINIC	38,938	2,179	41,117	19,180	60,297	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,758,555	1,767,348	4,525,903	-147,884	4,378,019	88.00
91.00	09100	EMERGENCY	2,230,490	1,208,759	3,439,249	58,391	3,497,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,044,434	65,714,936	92,759,370	117,880	92,877,250	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,321	31,321	1,030	32,351	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	872	269,557	270,429	-120,564	149,865	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	58,906	18,682	77,588	874	78,462	193.01
193.02	19302	FUND DEVELOPMENT	19,267	630,525	649,792	780	650,572	193.02
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	27,123,479	66,665,021	93,788,500	0	93,788,500	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-443,607	1,990,385	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,304,783	2,941,287	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,956,873	5,393,207	4.00
5.01	00540	NONPATIENT TELEPHONES	0	282,318	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	269,164	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-2,586,097	18,408,505	5.05
7.00	00700	OPERATION OF PLANT	-14,066	3,641,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	225,999	8.00
9.00	00900	HOUSEKEEPING	0	1,275,493	9.00
10.00	01000	DIETARY	-7,928	878,249	10.00
11.00	01100	CAFETERIA	-328,323	137,307	11.00
13.00	01300	NURSING ADMINISTRATION	799,596	2,210,698	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	371,634	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-275	305,744	16.00
17.00	01700	SOCIAL SERVICE	0	820,225	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,234,403	3,864,182	30.00
31.00	03100	INTENSIVE CARE UNIT	-262,240	2,573,726	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,743,475	50.00
51.00	05100	RECOVERY ROOM	0	384,770	51.00
53.00	05300	ANESTHESIOLOGY	-906,000	76,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-78,145	3,581,353	54.00
57.00	05700	CT SCAN	0	560,613	57.00
58.00	05800	MRI	0	159,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	-125,000	371,311	59.00
60.00	06000	LABORATORY	-78,578	3,862,251	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	164,547	62.00
64.00	06400	INTRAVENOUS THERAPY	0	427,427	64.00
65.00	06500	RESPIRATORY THERAPY	0	902,279	65.00
66.00	06600	PHYSICAL THERAPY	0	1,117,811	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	303,138	67.00
68.00	06800	SPEECH PATHOLOGY	0	251,847	68.00
69.00	06900	ELECTROCARDIOLOGY	-66,793	283,611	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-23,860	360,260	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,814,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,760,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-20,488	12,761,670	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-20,451	415,223	76.03
76.04	03952	PAIN CLINIC	0	60,297	76.04
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-20,103	4,357,916	88.00
91.00	09100	EMERGENCY	-573,133	2,924,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,641,984	85,235,266	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,351	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	149,865	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	EMS	0	78,462	193.01
193.02	19302	FUND DEVELOPMENT	0	650,572	193.02
194.00	07950	UNUSED SPACE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,641,984	86,146,516	200.00

RECLASSIFICATIONS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/25/2022 2:44 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SHORT TERM DISABILITY					
1.00	CAFETERIA	11.00	0	946		1.00
2.00	OPERATION OF PLANT	7.00	0	2,329		2.00
3.00	HOUSEKEEPING	9.00	0	988		3.00
4.00	NURSING ADMINISTRATION	13.00	0	652		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	21,085		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	9,187		6.00
7.00	OPERATING ROOM	50.00	0	4,619		7.00
8.00	RECOVERY ROOM	51.00	0	10,123		8.00
9.00	LABORATORY	60.00	0	1,181		9.00
10.00	INTRAVENOUS THERAPY	64.00	0	755		10.00
	0		0	51,865		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	313,355		1.00
2.00		0.00	0	0		2.00
	0		0	313,355		
	C - REHAB ADMINISTRATION					
1.00	OCCUPATIONAL THERAPY	67.00	16,736	28,855		1.00
2.00	SPEECH PATHOLOGY	68.00	13,904	23,973		2.00
	0		30,640	52,828		
	E - MINISTRY COST ALLOCATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	976,163		1.00
2.00	OPERATION OF PLANT	7.00	0	173,147		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	371,622		3.00
4.00	SOCIAL SERVICE	17.00	0	820,225		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	121,461		5.00
6.00	PHYSICAL THERAPY	66.00	0	53,222		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	11,406		7.00
8.00	SPEECH PATHOLOGY	68.00	0	9,477		8.00
	0		0	2,536,723		
	F - CANCER NAVIGATOR					
1.00	INTRAVENOUS THERAPY	64.00	44,621	0		1.00
	0		44,621	0		
	G - MSCTP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,839,341		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	1,839,341		
	H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,760,227		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	1,760,227		
	I - OTHER BENEFITS					
1.00	NONPATIENT TELEPHONES	5.01	3,747	0		1.00
2.00	PURCHASING RECEIVING AND STORES	5.02	645	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	236,936	0		3.00
4.00	OPERATION OF PLANT	7.00	15,352	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	790	0		5.00
6.00	HOUSEKEEPING	9.00	24,392	0		6.00
7.00	DIETARY	10.00	22,221	0		7.00
8.00	CAFETERIA	11.00	459	0		8.00
9.00	NURSING ADMINISTRATION	13.00	28,435	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	372	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	50,997	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	19,458	0		12.00
13.00	OPERATING ROOM	50.00	38,645	0		13.00
14.00	RECOVERY ROOM	51.00	4,366	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	50,925	0		15.00
16.00	CT SCAN	57.00	2,735	0		16.00
17.00	MRI	58.00	973	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	4,811	0		18.00
19.00	LABORATORY	60.00	30,013	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	8,135	0		20.00
21.00	RESPIRATORY THERAPY	65.00	8,394	0		21.00
22.00	PHYSICAL THERAPY	66.00	1,983	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	515	0		23.00
24.00	SPEECH PATHOLOGY	68.00	423	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	11,768	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	1,720	0		26.00

RECLASSIFICATIONS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/25/2022 2:44 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
27.00	DRUGS CHARGED TO PATIENTS	73.00	8,629	0	27.00
28.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03	15,676	0	28.00
29.00	PAIN CLINIC	76.04	832	0	29.00
30.00	RURAL HEALTH CLINIC	88.00	71,658	0	30.00
31.00	EMERGENCY	91.00	35,082	0	31.00
32.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	1,030	0	32.00
33.00	EMS	193.01	874	0	33.00
34.00	FUND DEVELOPMENT	193.02	780	0	34.00
0			703,771	0	
J - IMAGING MGR AND SPRVSR					
1.00	ELECTROENCEPHALOGRAPHY	70.00	10,033	0	1.00
2.00	PAIN CLINIC	76.04	5,017	0	2.00
3.00	CT SCAN	57.00	20,067	0	3.00
4.00	MRI	58.00	15,050	0	4.00
0			50,167	0	
K - STERILE PROCESSING					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	5,583	2,818	1.00
2.00	CT SCAN	57.00	5,583	2,818	2.00
3.00	RESPIRATORY THERAPY	65.00	7,444	3,016	3.00
4.00	PAIN CLINIC	76.04	5,583	2,818	4.00
5.00	EMERGENCY	91.00	13,026	10,283	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	9,304	8,404	6.00
0			46,523	30,157	
M - CARDIOLOGY MGR					
1.00	CARDIAC CATHETERIZATION	59.00	58,091	0	1.00
0			58,091	0	
N - ICU MGR					
1.00	RESPIRATORY THERAPY	65.00	16,524	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	11,016	0	2.00
0			27,540	0	
O - OSFMG HTM EXPENSE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,626,911	1.00
2.00	LABORATORY	60.00	0	115,509	2.00
0			0	1,742,420	
P - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	34,886	1.00
2.00		0.00	0	0	2.00
0			0	34,886	
Q - SURGERY SALARIES					
1.00	RECOVERY ROOM	51.00	19,896	0	1.00
2.00	ANESTHESIOLOGY	53.00	9,948	0	2.00
0			29,844	0	
R - RADIOLOGY MANAGER SALARIE					
1.00	PAIN CLINIC	76.04	4,930	0	1.00
2.00	CT SCAN	57.00	14,790	0	2.00
3.00	MRI	58.00	9,860	0	3.00
4.00	ELECTROENCEPHALOGRAPHY	70.00	4,930	0	4.00
0			34,510	0	
S - MINISTRY- OSFMG OVERHEAD					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	219,542	1.00
0			0	219,542	
500.00	Grand Total: Increases		1,025,707	8,581,344	500.00

RECLASSIFICATIONS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Date/Time Prepared:
2/25/2022 2:44 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SHORT TERM DISABILITY						
1.00	CAFETERIA	11.00	946	0	0		1.00
2.00	OPERATION OF PLANT	7.00	2,329	0	0		2.00
3.00	HOUSEKEEPING	9.00	988	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	652	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	21,085	0	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	9,187	0	0		6.00
7.00	OPERATING ROOM	50.00	4,619	0	0		7.00
8.00	RECOVERY ROOM	51.00	10,123	0	0		8.00
9.00	LABORATORY	60.00	1,181	0	0		9.00
10.00	INTRAVENOUS THERAPY	64.00	755	0	0		10.00
	0		51,865	0			
	B - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	175,083	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	138,272	0		2.00
	0		0	313,355			
	C - REHAB ADMINISTRATION						
1.00	PHYSICAL THERAPY	66.00	30,640	52,828	0		1.00
2.00		0.00	0	0	0		2.00
	0		30,640	52,828			
	E - MINISTRY COST ALLOCATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	2,536,723	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		0	2,536,723			
	F - CANCER NAVIGATOR						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	44,621	0	0		1.00
	0		44,621	0			
	G - MSCTP						
1.00	OPERATING ROOM	50.00	0	1,511,744	0		1.00
2.00	CT SCAN	57.00	0	725	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	326,872	0		3.00
	0		0	1,839,341			
	H - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	1,470,043	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,434	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	272,750	0		3.00
	0		0	1,760,227			
	I - OTHER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	614,680	89,091	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00

RECLASSIFICATIONS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/25/2022 2:44 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
0			614,680	89,091			
J - IMAGING MGR AND SPRVSR							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	50,167	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
0			50,167	0			
K - STERILE PROCESSING							
1.00	OPERATING ROOM	50.00	46,523	30,157	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
0			46,523	30,157			
M - CARDIOLOGY MGR							
1.00	ELECTROCARDIOLOGY	69.00	58,091	0	0		1.00
0			58,091	0			
N - ICU MGR							
1.00	INTENSIVE CARE UNIT	31.00	27,540	0	0		1.00
2.00		0.00	0	0	0		2.00
0			27,540	0			
O - OSFMG HTM EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	1,742,420	0		1.00
2.00		0.00	0	0	0		2.00
0			0	1,742,420			
P - DRUGS CHARGED TO PATIENTS							
1.00	CT SCAN	57.00	0	524	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	34,362	0		2.00
0			0	34,886			
Q - SURGERY SALARIES							
1.00	OPERATING ROOM	50.00	29,844	0	0		1.00
2.00		0.00	0	0	0		2.00
0			29,844	0			
R - RADIOLOGY MANAGER SALARIE							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	34,510	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
0			34,510	0			
S - MINISTRY- OSFMG OVERHEAD							
1.00	RURAL HEALTH CLINIC	88.00	0	219,542	0		1.00
	TOTALS		0	219,542			
500.00	Grand Total: Decreases		988,481	8,618,570			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,080,000	0	0	0	0	1.00	
2.00	Land Improvements	7,015,927	0	0	0	0	2.00	
3.00	Buildings and Fixtures	64,163,398	1,394,697	0	1,394,697	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	34,257,269	1,515,808	0	1,515,808	1,562,976	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	106,516,594	2,910,505	0	2,910,505	1,562,976	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	106,516,594	2,910,505	0	2,910,505	1,562,976	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,080,000	0				1.00	
2.00	Land Improvements	7,015,927	0				2.00	
3.00	Buildings and Fixtures	65,558,095	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	34,210,101	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	107,864,123	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	107,864,123	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,221,416	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,535,725	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,757,141	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,221,416				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,535,725				2.00
3.00	Total (sum of lines 1-2)	0	3,757,141				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	72,259,325	0	72,259,325	0.678386	118,774	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,257,269	0	34,257,269	0.321614	56,309	2.00
3.00	Total (sum of lines 1-2)	106,516,594	0	106,516,594	1.000000	175,083	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	93,802	0	212,576	1,777,809	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	44,470	0	100,779	2,840,508	0	2.00
3.00	Total (sum of lines 1-2)	138,272	0	313,355	4,618,317	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	118,774	93,802	0	1,990,385	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	56,309	44,470	0	2,941,287	2.00
3.00	Total (sum of lines 1-2)	0	175,083	138,272	0	4,931,672	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,376,058			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-310,445			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-328,323	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-275	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-65,170	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	217,925	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	351,879	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER OPERATING REVENUES - ADMIN AND	B	-14,558	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.00
33.01	OTHER OPERATING REVENUES - PATIENT A	B	-20,103	RURAL HEALTH CLINIC	88.00	0	33.01
33.02	OTHER OPERATING REVENUES - DIETARY	B	-7,928	DIETARY	10.00	0	33.02
33.03	OTHER OPERATING REVENUES - MED PSYCH	B	-20,451	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03	0	33.03
33.04	OTHER OPERATING REVENUES - LAB	B	-1,000	LABORATORY	60.00	0	33.04
33.05	PENSION COST	A	1,170,595	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	340B OFFSET	B	-20,488	DRUGS CHARGED TO PATIENTS	73.00	0	33.06
33.07	MEDICAID PROVIDER TAX	A	-4,938,846	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.07
33.08	OCC MED	A	-105,144	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	CARDIOLOGY SVCS	B	-35,000	CARDIAC CATHETERIZATION	59.00	0	33.09
33.10	ADVERTISING - ADMIN	A	-310	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	ADVERTISING - EKG	A	-648	ELECTROCARDIOLOGY	69.00	0	33.11
33.12	OCC MED	A	-105,144	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	RECRUITING EXPENSE - ICU	A	-900	ADULTS & PEDIATRICS	30.00	0	33.13
33.14	RECRUITING EXPENSE - SURGERY	A	-5,000	LABORATORY	60.00	0	33.14
33.15	PHYSICIAN EMPLOYEE PART B EB	A	-2,376	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	LOBBYING DUES	A	-24,216	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,641,984				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/25/2022 2:44 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	MINISTRY - CAPITAL BLDG	230,873	892,405	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MINISTRY - CAPITAL EQUIPMEN	952,904	0	2.00
3.00	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY - POOLED EB	976,163	976,163	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY - POOLED A&G	5,968,204	9,883,008	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY - POOLED ENGINEERI	173,147	173,147	3.02
3.03	31.00	INTENSIVE CARE UNIT	MINISTRY - POOLED EICU	159,058	159,058	3.03
3.04	66.00	PHYSICAL THERAPY	MINISTRY - POOLED PT	53,222	53,222	3.04
3.05	67.00	OCCUPATIONAL THERAPY	MINISTRY - POOLED OT	11,406	11,406	3.05
3.06	68.00	SPEECH PATHOLOGY	MINISTRY - POOLED ST	9,477	9,477	3.06
3.07	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY - POOLED PHARMACY	474,522	474,522	3.07
3.08	88.00	RURAL HEALTH CLINIC	MINISTRY - POOLED RHC	219,542	219,542	3.08
3.12	13.00	NURSING ADMINISTRATION	MINISTRY - FUNCTIONAL NURSI	941,824	0	3.12
3.13	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY -FUNCTIONAL 340B	11,141	0	3.13
3.14	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY- FUNCTIONAL REGIONA	696,951	0	3.14
3.15	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY- FUNCTIONAL SUPPLY	148,472	0	3.15
4.00	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY - FUNCTIONAL ADMIN	4,310,768	2,903,235	4.00
4.01	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY - FUNCTIONAL CARE	930,045	820,225	4.01
4.02	5.05	OTHER ADMINISTRATIVE AND GEN	MINISTRY - FUNCTIONAL CARE	95,005	0	4.02
4.03	7.00	OPERATION OF PLANT	PCI / HTM - ENGINEERING	335,986	352,938	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	PCI / HTM - IMAGING	1,548,766	1,626,911	4.04
4.05	60.00	LABORATORY	PCI / HTM - LAB	109,961	115,509	4.05
4.06	60.00	LABORATORY	SYSTEMS LAB	954,198	954,198	4.06
4.07	5.05	OTHER ADMINISTRATIVE AND GEN	SFI / PCI CREDENTIALING	72,118	72,118	4.07
4.08	7.00	OPERATION OF PLANT	SFI / PCI BIOMED	7,972	5,086	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
4.11	0.00			0	0	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			19,391,725	19,702,170	5.00

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

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

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

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

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

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

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

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

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

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/25/2022 2:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-661,532	9		1.00
2.00	952,904	9		2.00
3.00	0	0		3.00
3.01	-3,914,804	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	11		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.12	941,824	0		3.12
3.13	11,141	0		3.13
3.14	696,951	0		3.14
3.15	148,472	0		3.15
4.00	1,407,533	0		4.00
4.01	109,820	0		4.01
4.02	95,005	0		4.02
4.03	-16,952	0		4.03
4.04	-78,145	0		4.04
4.05	-5,548	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	2,886	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
5.00	-310,445			5.00

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

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

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

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

6.00	CATHOLIC SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/25/2022 2:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	11,919	11,919	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	142,228	142,228	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,233,503	1,233,503	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	262,240	262,240	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	906,000	906,000	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	90,000	90,000	0	0	0	6.00
7.00	60.00	LABORATORY	67,030	67,030	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	66,145	66,145	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	23,860	23,860	0	0	0	9.00
10.00	91.00	EMERGENCY	573,133	573,133	0	0	0	10.00
200.00			3,376,058	3,376,058	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	5.05	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	5.05	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	11,919		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	142,228		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,233,503		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	262,240		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	906,000		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	90,000		6.00
7.00	60.00	LABORATORY	0	0	0	67,030		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	66,145		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	23,860		9.00
10.00	91.00	EMERGENCY	0	0	0	573,133		10.00
200.00			0	0	0	3,376,058		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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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	1,990,385	1,990,385			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,941,287		2,941,287		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,393,207	1,018	0	5,394,225	4.00
5.01	00540	NONPATIENT TELEPHONES	282,318	2,072	10,345	49,868	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	269,164	18,294	184	60,914	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	18,408,505	114,581	1,151,520	293,344	5.05
7.00	00700	OPERATION OF PLANT	3,641,355	100,595	42,167	194,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	225,999	5,589	0	3,961	8.00
9.00	00900	HOUSEKEEPING	1,275,493	25,010	3,098	171,971	9.00
10.00	01000	DIETARY	878,249	30,756	34,225	115,059	10.00
11.00	01100	CAFETERIA	137,307	14,884	29,049	43,160	11.00
13.00	01300	NURSING ADMINISTRATION	2,210,698	4,126	86,306	242,902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	371,634	20,968	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	305,744	10,313	0	35,119	16.00
17.00	01700	SOCIAL SERVICE	820,225	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,864,182	168,330	87,075	618,688	30.00
31.00	03100	INTENSIVE CARE UNIT	2,573,726	55,441	119,538	281,624	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,743,475	89,531	472,015	476,209	50.00
51.00	05100	RECOVERY ROOM	384,770	3,619	15,724	67,850	51.00
53.00	05300	ANESTHESIOLOGY	76,912	365	42,277	1,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,581,353	55,532	507,513	379,171	54.00
57.00	05700	CT SCAN	560,613	3,414	6,796	54,272	57.00
58.00	05800	MRI	159,430	2,937	0	26,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	371,311	8,117	16,129	91,232	59.00
60.00	06000	LABORATORY	3,862,251	47,718	70,151	294,226	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	164,547	237	1,485	0	62.00
64.00	06400	INTRAVENOUS THERAPY	427,427	16,521	28,908	112,485	64.00
65.00	06500	RESPIRATORY THERAPY	902,279	7,949	15,225	140,057	65.00
66.00	06600	PHYSICAL THERAPY	1,117,811	3,447	30,185	181,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	303,138	792	10,957	51,966	67.00
68.00	06800	SPEECH PATHOLOGY	251,847	0	8,640	42,674	68.00
69.00	06900	ELECTROCARDIOLOGY	283,611	11,050	44,619	54,461	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	360,260	15,365	2,411	24,007	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,814,913	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,760,227	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,761,670	20,093	53,832	158,234	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	415,223	33,849	1,035	85,562	76.03
76.04	03952	PAIN CLINIC	60,297	1,849	4,094	10,990	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,357,916	0	0	562,468	88.00
91.00	09100	EMERGENCY	2,924,507	48,171	34,705	450,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,235,266	942,533	2,930,208	5,376,134	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,351	3,327	0	205	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	149,865	119,779	9,475	2,022	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	EMS	78,462	569	1,604	11,880	193.01
193.02	19302	FUND DEVELOPMENT	650,572	0	0	3,984	193.02
194.00	07950	UNUSED SPACE	0	924,177	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	86,146,516	1,990,385	2,941,287	5,394,225	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			NONPATIENT TELEPHONES	Subtotal	PURCHASING RECEIVING AND STORES	Subtotal	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	344,603					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,400	349,956	349,956			5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	80,215	20,048,165	81,766	20,129,931	0	5.05
7.00	00700	OPERATION OF PLANT	15,977	3,994,425	16,293	4,010,718	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	946	236,495	965	237,460	0	8.00
9.00	00900	HOUSEKEEPING	5,926	1,481,498	6,043	1,487,541	0	9.00
10.00	01000	DIETARY	4,250	1,062,539	4,334	1,066,873	0	10.00
11.00	01100	CAFETERIA	901	225,301	919	226,220	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,217	2,554,249	10,419	2,564,668	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,577	394,179	1,608	395,787	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,410	352,586	1,438	354,024	0	16.00
17.00	01700	SOCIAL SERVICE	3,294	823,519	3,359	826,878	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,029	4,757,304	19,405	4,776,709	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,170	3,042,499	12,410	3,054,909	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,185	3,796,415	15,486	3,811,901	0	50.00
51.00	05100	RECOVERY ROOM	1,895	473,858	1,933	475,791	0	51.00
53.00	05300	ANESTHESIOLOGY	488	122,019	498	122,517	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,167	4,541,736	18,526	4,560,262	0	54.00
57.00	05700	CT SCAN	2,510	627,605	2,560	630,165	0	57.00
58.00	05800	MRI	757	189,320	772	190,092	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,955	488,744	1,994	490,738	0	59.00
60.00	06000	LABORATORY	17,166	4,291,512	17,505	4,309,017	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	668	166,937	681	167,618	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2,351	587,692	2,397	590,089	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,279	1,069,789	4,364	1,074,153	0	65.00
66.00	06600	PHYSICAL THERAPY	5,352	1,337,943	5,457	1,343,400	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,473	368,326	1,502	369,828	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,217	304,378	1,242	305,620	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,581	395,322	1,613	396,935	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,615	403,658	1,647	405,305	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,289	1,822,202	7,433	1,829,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,069	1,767,296	7,209	1,774,505	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,183	13,046,012	53,215	13,099,227	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,151	537,820	2,194	540,014	0	76.03
76.04	03952	PAIN CLINIC	310	77,540	316	77,856	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	19,760	4,940,144	20,151	4,960,295	0	88.00
91.00	09100	EMERGENCY	13,885	3,471,276	14,159	3,485,435	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	336,618	84,150,259	341,813	84,142,116	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	36,027	147	36,174	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,129	282,270	1,151	283,421	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	372	92,887	379	93,266	0	193.01
193.02	19302	FUND DEVELOPMENT	2,629	657,185	2,681	659,866	0	193.02
194.00	07950	UNUSED SPACE	3,711	927,888	3,785	931,673	0	194.00
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	344,603	86,146,516	349,956	86,146,516	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.04	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	20,129,931	20,129,931				5.05
7.00	00700	OPERATION OF PLANT	4,010,718	1,222,956	5,233,674			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	237,460	72,407	15,937	325,804		8.00
9.00	00900	HOUSEKEEPING	1,487,541	453,584	71,320	0	2,012,445	9.00
10.00	01000	DIETARY	1,066,873	325,313	87,704	0	70,291	10.00
11.00	01100	CAFETERIA	226,220	68,979	42,443	0	34,016	11.00
13.00	01300	NURSING ADMINISTRATION	2,564,668	782,024	11,765	0	9,429	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	395,787	120,684	59,794	0	47,922	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354,024	107,950	29,408	0	23,569	16.00
17.00	01700	SOCIAL SERVICE	826,878	252,133	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,776,709	1,456,524	480,017	106,135	384,714	30.00
31.00	03100	INTENSIVE CARE UNIT	3,054,909	931,509	158,098	27,083	126,709	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,811,901	1,162,332	255,311	45,564	204,620	50.00
51.00	05100	RECOVERY ROOM	475,791	145,079	10,319	0	8,271	51.00
53.00	05300	ANESTHESIOLOGY	122,517	37,358	1,040	0	834	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,560,262	1,390,524	158,359	39,598	126,917	54.00
57.00	05700	CT SCAN	630,165	192,151	9,737	0	7,804	57.00
58.00	05800	MRI	190,092	57,963	8,374	0	6,711	58.00
59.00	05900	CARDIAC CATHETERIZATION	490,738	149,637	23,146	20,247	18,550	59.00
60.00	06000	LABORATORY	4,309,017	1,313,914	136,076	0	109,059	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	167,618	51,110	676	0	542	62.00
64.00	06400	INTRAVENOUS THERAPY	590,089	179,931	47,113	11,302	37,759	64.00
65.00	06500	RESPIRATORY THERAPY	1,074,153	327,533	22,667	0	18,167	65.00
66.00	06600	PHYSICAL THERAPY	1,343,400	409,632	41,777	0	33,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,828	112,769	34,204	0	27,413	67.00
68.00	06800	SPEECH PATHOLOGY	305,620	93,190	31,946	0	25,604	68.00
69.00	06900	ELECTROCARDIOLOGY	396,935	121,034	31,509	0	25,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	405,305	123,586	43,816	425	35,116	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,829,635	557,896	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,774,505	541,086	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,099,227	3,994,266	57,297	0	45,921	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	540,014	164,662	96,526	0	77,361	76.03
76.04	03952	PAIN CLINIC	77,856	23,740	5,274	0	4,227	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,960,295	1,512,503	136,544	0	109,434	88.00
91.00	09100	EMERGENCY	3,485,435	1,062,786	137,366	75,450	110,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,142,116	19,518,745	2,245,563	325,804	1,729,788	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,174	11,030	9,487	0	7,604	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	283,421	86,421	341,569	0	273,752	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	93,266	28,439	1,623	0	1,301	193.01
193.02	19302	FUND DEVELOPMENT	659,866	201,208	0	0	0	193.02
194.00	07950	UNUSED SPACE	931,673	284,088	2,635,432	0	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,146,516	20,129,931	5,233,674	325,804	2,012,445	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,550,181					10.00
11.00	01100	CAFETERIA	1,235,804	1,607,462				11.00
13.00	01300	NURSING ADMINISTRATION	0	69,399	3,437,285			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	624,187		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,675	0	128	535,754	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	265,437	250,991	919,881	85,192	14,645	30.00
31.00	03100	INTENSIVE CARE UNIT	34,163	97,344	432,324	55,122	7,082	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	809	172,723	827,753	0	49,720	50.00
51.00	05100	RECOVERY ROOM	0	20,057	101,476	11,952	7,202	51.00
53.00	05300	ANESTHESIOLOGY	0	516	0	27,239	5,154	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,985	29,394	68,923	51,605	54.00
57.00	05700	CT SCAN	0	21,036	1,948	36,761	59,997	57.00
58.00	05800	MRI	0	10,363	0	10,850	7,746	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	29,956	104,313	0	10,397	59.00
60.00	06000	LABORATORY	0	132,353	13,689	53,564	59,698	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	1,902	62.00
64.00	06400	INTRAVENOUS THERAPY	0	49,548	118,087	29,297	7,540	64.00
65.00	06500	RESPIRATORY THERAPY	0	51,611	0	53,325	8,822	65.00
66.00	06600	PHYSICAL THERAPY	0	54,962	0	3,439	10,989	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,313	0	233	2,719	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,941	0	63	1,119	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,880	40,143	1,656	19,307	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,240	0	1,841	7,350	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,360	9,533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,909	0	5,872	115,056	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,595	0	250	1,117	76.03
76.04	03952	PAIN CLINIC	0	6,496	0	756	149	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	171,847	231,799	13,937	10,181	88.00
91.00	09100	EMERGENCY	9,473	167,722	606,447	128,262	51,486	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,545,686	1,607,462	3,427,254	624,022	535,754	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,495	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	0	0	0	165	0	193.01
193.02	19302	FUND DEVELOPMENT	0	0	10,031	0	0	193.02
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,550,181	1,607,462	3,437,285	624,187	535,754	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL					5.05
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	1,079,011				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	922,866	9,663,111	0	9,663,111	30.00
31.00	03100	INTENSIVE CARE UNIT	156,145	5,080,488	0	5,080,488	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	6,530,733	0	6,530,733	50.00
51.00	05100	RECOVERY ROOM	0	780,147	0	780,147	51.00
53.00	05300	ANESTHESIOLOGY	0	194,658	0	194,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,570,567	0	6,570,567	54.00
57.00	05700	CT SCAN	0	959,599	0	959,599	57.00
58.00	05800	MRI	0	292,099	0	292,099	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	846,984	0	846,984	59.00
60.00	06000	LABORATORY	0	6,127,370	0	6,127,370	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	221,848	0	221,848	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,070,666	0	1,070,666	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,556,278	0	1,556,278	65.00
66.00	06600	PHYSICAL THERAPY	0	1,897,681	0	1,897,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	562,479	0	562,479	67.00
68.00	06800	SPEECH PATHOLOGY	0	470,483	0	470,483	68.00
69.00	06900	ELECTROCARDIOLOGY	0	651,717	0	651,717	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	628,679	0	628,679	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,432,424	0	2,432,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,330,829	0	2,330,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,367,548	0	17,367,548	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	909,525	0	909,525	76.03
76.04	03952	PAIN CLINIC	0	118,498	0	118,498	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	7,146,540	0	7,146,540	88.00
91.00	09100	EMERGENCY	0	5,834,520	0	5,834,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,079,011	80,245,471	0	80,245,471	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	64,295	0	64,295	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	989,658	0	989,658	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	EMS	0	124,794	0	124,794	193.01
193.02	19302	FUND DEVELOPMENT	0	871,105	0	871,105	193.02
194.00	07950	UNUSED SPACE	0	3,851,193	0	3,851,193	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,079,011	86,146,516	0	86,146,516	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
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	1,035	1,018	0	2,053	4.00
5.01	00540	NONPATIENT TELEPHONES	126	2,072	10,345	12,543	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	258	18,294	184	18,736	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	31,179	114,581	1,151,520	1,297,280	5.05
7.00	00700	OPERATION OF PLANT	14,247	100,595	42,167	157,009	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,589	0	5,589	8.00
9.00	00900	HOUSEKEEPING	0	25,010	3,098	28,108	9.00
10.00	01000	DIETARY	0	30,756	34,225	64,981	10.00
11.00	01100	CAFETERIA	0	14,884	29,049	43,933	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,126	86,306	90,432	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,968	0	20,968	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,313	0	10,313	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,049	168,330	87,075	281,454	30.00
31.00	03100	INTENSIVE CARE UNIT	12,092	55,441	119,538	187,071	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,868	89,531	472,015	578,414	50.00
51.00	05100	RECOVERY ROOM	0	3,619	15,724	19,343	51.00
53.00	05300	ANESTHESIOLOGY	0	365	42,277	42,642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,073	55,532	507,513	564,118	54.00
57.00	05700	CT SCAN	0	3,414	6,796	10,210	57.00
58.00	05800	MRI	0	2,937	0	2,937	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,117	16,129	24,246	59.00
60.00	06000	LABORATORY	9,659	47,718	70,151	127,528	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	237	1,485	1,722	62.00
64.00	06400	INTRAVENOUS THERAPY	239	16,521	28,908	45,668	64.00
65.00	06500	RESPIRATORY THERAPY	16,457	7,949	15,225	39,631	65.00
66.00	06600	PHYSICAL THERAPY	131,743	3,447	30,185	165,375	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,235	792	10,957	39,984	67.00
68.00	06800	SPEECH PATHOLOGY	23,458	0	8,640	32,098	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,050	44,619	55,669	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11	15,365	2,411	17,787	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	375	20,093	53,832	74,300	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	33,849	1,035	34,884	76.03
76.04	03952	PAIN CLINIC	0	1,849	4,094	5,943	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	510,701	0	0	510,701	88.00
91.00	09100	EMERGENCY	848	48,171	34,705	83,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	824,653	942,533	2,930,208	4,697,394	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,327	0	3,327	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	119,779	9,475	129,254	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	EMS	0	569	1,604	2,173	193.01
193.02	19302	FUND DEVELOPMENT	0	0	0	0	193.02
194.00	07950	UNUSED SPACE	0	924,177	0	924,177	194.00
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)	824,653	1,990,385	2,941,287	5,756,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description			NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.04	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	12,562					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	51	18,810				5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0			5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	2,951	4,412	0	1,304,755		5.05
7.00	00700	OPERATION OF PLANT	581	875	0	79,268	237,807	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34	52	0	4,693	724	8.00
9.00	00900	HOUSEKEEPING	215	324	0	29,400	3,241	9.00
10.00	01000	DIETARY	155	233	0	21,086	3,985	10.00
11.00	01100	CAFETERIA	33	49	0	4,471	1,928	11.00
13.00	01300	NURSING ADMINISTRATION	371	559	0	50,688	535	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57	86	0	7,822	2,717	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51	77	0	6,997	1,336	16.00
17.00	01700	SOCIAL SERVICE	120	180	0	16,342	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	692	1,042	0	94,407	21,811	30.00
31.00	03100	INTENSIVE CARE UNIT	442	666	0	60,377	7,184	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	552	831	0	75,338	11,601	50.00
51.00	05100	RECOVERY ROOM	69	104	0	9,404	469	51.00
53.00	05300	ANESTHESIOLOGY	18	27	0	2,421	47	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	660	995	0	90,129	7,195	54.00
57.00	05700	CT SCAN	91	137	0	12,455	442	57.00
58.00	05800	MRI	28	41	0	3,757	381	58.00
59.00	05900	CARDIAC CATHETERIZATION	71	107	0	9,699	1,052	59.00
60.00	06000	LABORATORY	624	940	0	85,163	6,183	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	24	37	0	3,313	31	62.00
64.00	06400	INTRAVENOUS THERAPY	85	129	0	11,663	2,141	64.00
65.00	06500	RESPIRATORY THERAPY	156	234	0	21,230	1,030	65.00
66.00	06600	PHYSICAL THERAPY	195	293	0	26,551	1,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	54	81	0	7,309	1,554	67.00
68.00	06800	SPEECH PATHOLOGY	44	67	0	6,040	1,452	68.00
69.00	06900	ELECTROCARDIOLOGY	57	87	0	7,845	1,432	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	59	88	0	8,010	1,991	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	265	399	0	36,161	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	257	387	0	35,071	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,897	2,857	0	258,896	2,603	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	78	118	0	10,673	4,386	76.03
76.04	03952	PAIN CLINIC	11	17	0	1,539	240	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	718	1,082	0	98,035	6,204	88.00
91.00	09100	EMERGENCY	505	760	0	68,886	6,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,271	18,373	0	1,265,139	102,035	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5	8	0	715	431	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41	62	0	5,602	15,520	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	14	20	0	1,843	74	193.01
193.02	19302	FUND DEVELOPMENT	96	144	0	13,042	0	193.02
194.00	07950	UNUSED SPACE	135	203	0	18,414	119,747	194.00
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)	12,562	18,810	0	1,304,755	237,807	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,094					8.00
9.00	00900	HOUSEKEEPING	0	61,354				9.00
10.00	01000	DIETARY	0	2,143	92,627			10.00
11.00	01100	CAFETERIA	0	1,037	73,843	125,311		11.00
13.00	01300	NURSING ADMINISTRATION	0	287	0	5,410	148,375	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,461	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	719	0	1,612	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,616	11,727	15,860	19,565	39,708	30.00
31.00	03100	INTENSIVE CARE UNIT	922	3,863	2,041	7,589	18,662	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,551	6,238	48	13,465	35,731	50.00
51.00	05100	RECOVERY ROOM	0	252	0	1,564	4,380	51.00
53.00	05300	ANESTHESIOLOGY	0	25	0	40	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,348	3,869	0	11,302	1,269	54.00
57.00	05700	CT SCAN	0	238	0	1,640	84	57.00
58.00	05800	MRI	0	205	0	808	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	689	566	0	2,335	4,503	59.00
60.00	06000	LABORATORY	0	3,325	0	10,318	591	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	17	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	385	1,151	0	3,863	5,097	64.00
65.00	06500	RESPIRATORY THERAPY	0	554	0	4,023	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,021	0	4,285	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	836	0	1,194	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	781	0	1,009	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	770	0	1,238	1,733	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14	1,071	0	876	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,400	0	3,891	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,359	0	2,307	0	76.03
76.04	03952	PAIN CLINIC	0	129	0	506	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,336	0	13,396	10,006	88.00
91.00	09100	EMERGENCY	2,569	3,356	566	13,075	26,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,094	52,736	92,358	125,311	147,942	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	232	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,346	269	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	0	40	0	0	0	193.01
193.02	19302	FUND DEVELOPMENT	0	0	0	0	433	193.02
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
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)	11,094	61,354	92,627	125,311	148,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	33,111					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	21,125				16.00
17.00	01700	SOCIAL SERVICE	0	0	16,642			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,519	572	14,234	509,431	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,924	277	2,408	294,534	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,943	0	725,894	0	50.00
51.00	05100	RECOVERY ROOM	634	281	0	36,526	0	51.00
53.00	05300	ANESTHESIOLOGY	1,445	201	0	46,867	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,656	2,017	0	686,703	0	54.00
57.00	05700	CT SCAN	1,950	2,345	0	29,613	0	57.00
58.00	05800	MRI	576	303	0	9,046	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	406	0	43,709	0	59.00
60.00	06000	LABORATORY	2,841	2,333	0	239,959	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	74	0	5,218	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,554	295	0	72,074	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,829	345	0	70,086	0	65.00
66.00	06600	PHYSICAL THERAPY	182	430	0	200,299	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	12	106	0	51,150	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	44	0	41,554	0	68.00
69.00	06900	ELECTROCARDIOLOGY	88	755	0	69,695	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	98	287	0	30,290	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,876	373	0	39,074	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	596	0	36,311	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	311	4,682	0	350,898	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	13	44	0	54,895	0	76.03
76.04	03952	PAIN CLINIC	40	6	0	8,435	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	739	398	0	644,830	0	88.00
91.00	09100	EMERGENCY	6,805	2,012	0	214,850	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,102	21,125	16,642	4,511,941	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,718	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	159,095	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	9	0	0	4,178	0	193.01
193.02	19302	FUND DEVELOPMENT	0	0	0	13,717	0	193.02
194.00	07950	UNUSED SPACE	0	0	0	1,062,676	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,111	21,125	16,642	5,756,325	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	5.05
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03
76.04	03952	PAIN CLINIC	76.04
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	EMS	193.01
193.02	19302	FUND DEVELOPMENT	193.02
194.00	07950	UNUSED SPACE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	NONPATIENT TELEPHONES (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A.01	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	545,622				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,847,394			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	279	0	27,142,572		4.00
5.01	00540	NONPATIENT TELEPHONES	568	10,015	250,924	-344,603	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5,015	178	306,507	0	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	31,410	1,114,761	1,476,039	0	5.05
7.00	00700	OPERATION OF PLANT	27,576	40,821	977,828	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	0	19,931	0	8.00
9.00	00900	HOUSEKEEPING	6,856	2,999	865,321	0	9.00
10.00	01000	DIETARY	8,431	33,132	578,953	0	10.00
11.00	01100	CAFETERIA	4,080	28,122	217,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,131	83,551	1,222,229	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,748	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,827	0	176,711	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	46,144	84,295	3,113,137	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,198	115,722	1,417,069	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,543	456,947	2,396,177	0	50.00
51.00	05100	RECOVERY ROOM	992	15,222	341,404	0	51.00
53.00	05300	ANESTHESIOLOGY	100	40,927	9,948	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,223	491,312	1,907,903	0	54.00
57.00	05700	CT SCAN	936	6,579	273,087	0	57.00
58.00	05800	MRI	805	0	131,812	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,225	15,614	459,058	0	59.00
60.00	06000	LABORATORY	13,081	67,912	1,480,480	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65	1,438	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	4,529	27,985	566,000	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,179	14,739	704,733	0	65.00
66.00	06600	PHYSICAL THERAPY	945	29,221	911,497	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	217	10,607	261,482	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,364	214,724	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,029	43,195	274,035	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,212	2,334	120,798	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,508	52,114	796,199	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,279	1,002	430,531	0	76.03
76.04	03952	PAIN CLINIC	507	3,963	55,300	0	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	2,830,213	0	88.00
91.00	09100	EMERGENCY	13,205	33,597	2,264,338	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,375	2,836,668	27,051,539	-344,603	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	912	0	1,030	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,835	9,173	10,176	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	EMS	156	1,553	59,780	0	193.01
193.02	19302	FUND DEVELOPMENT	0	0	20,047	0	193.02
194.00	07950	UNUSED SPACE	253,344	0	0	0	194.00
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)	1,990,385	2,941,287	5,394,225	344,603	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.647919	1.032975	0.198737	0.004016	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,053	12,562	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000076	0.000146	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	NONPATIENT TELEPHONES (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A.01	5.01	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Reconciliation	PURCHASING RECEIVING AND STORES (ACCUM. COST)	Reconciliation	CASHIERING/ACC OUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
		5A.02	5.02	5A.04	5.04	5A.05	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-349,956	85,796,560			5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	86,146,516	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	20,048,165	0	20,129,931	5.05
7.00	00700	OPERATION OF PLANT	0	3,994,425	0	4,010,718	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	236,495	0	237,460	8.00
9.00	00900	HOUSEKEEPING	0	1,481,498	0	1,487,541	9.00
10.00	01000	DIETARY	0	1,062,539	0	1,066,873	10.00
11.00	01100	CAFETERIA	0	225,301	0	226,220	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,554,249	0	2,564,668	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	394,179	0	395,787	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	352,586	0	354,024	16.00
17.00	01700	SOCIAL SERVICE	0	823,519	0	826,878	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,757,304	0	4,776,709	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,042,499	0	3,054,909	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,796,415	0	3,811,901	50.00
51.00	05100	RECOVERY ROOM	0	473,858	0	475,791	51.00
53.00	05300	ANESTHESIOLOGY	0	122,019	0	122,517	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,541,736	0	4,560,262	54.00
57.00	05700	CT SCAN	0	627,605	0	630,165	57.00
58.00	05800	MRI	0	189,320	0	190,092	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	488,744	0	490,738	59.00
60.00	06000	LABORATORY	0	4,291,512	0	4,309,017	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	166,937	0	167,618	62.00
64.00	06400	INTRAVENOUS THERAPY	0	587,692	0	590,089	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,069,789	0	1,074,153	65.00
66.00	06600	PHYSICAL THERAPY	0	1,337,943	0	1,343,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	368,326	0	369,828	67.00
68.00	06800	SPEECH PATHOLOGY	0	304,378	0	305,620	68.00
69.00	06900	ELECTROCARDIOLOGY	0	395,322	0	396,935	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	403,658	0	405,305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,822,202	0	1,829,635	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,767,296	0	1,774,505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,046,012	0	13,099,227	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	537,820	0	540,014	76.03
76.04	03952	PAIN CLINIC	0	77,540	0	77,856	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,940,144	0	4,960,295	88.00
91.00	09100	EMERGENCY	0	3,471,276	0	3,485,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-349,956	83,800,303	0	84,142,116	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36,027	0	36,174	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	282,270	0	283,421	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	EMS	0	92,887	0	93,266	193.01
193.02	19302	FUND DEVELOPMENT	0	657,185	0	659,866	193.02
194.00	07950	UNUSED SPACE	0	927,888	0	931,673	194.00
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)		349,956		0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.004079		0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		18,810		0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000219		0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT ME ALS)	
		5.05	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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	66,016,585				5.05
7.00	00700	OPERATION OF PLANT	4,010,718	503,113			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	237,460	1,532	291,348		8.00
9.00	00900	HOUSEKEEPING	1,487,541	6,856	0	241,381	9.00
10.00	01000	DIETARY	1,066,873	8,431	0	8,431	10.00
11.00	01100	CAFETERIA	226,220	4,080	0	4,080	11.00
13.00	01300	NURSING ADMINISTRATION	2,564,668	1,131	0	1,131	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	395,787	5,748	0	5,748	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354,024	2,827	0	2,827	16.00
17.00	01700	SOCIAL SERVICE	826,878	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,776,709	46,144	94,910	46,144	30.00
31.00	03100	INTENSIVE CARE UNIT	3,054,909	15,198	24,219	15,198	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,811,901	24,543	40,745	24,543	50.00
51.00	05100	RECOVERY ROOM	475,791	992	0	992	51.00
53.00	05300	ANESTHESIOLOGY	122,517	100	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,560,262	15,223	35,410	15,223	54.00
57.00	05700	CT SCAN	630,165	936	0	936	57.00
58.00	05800	MRI	190,092	805	0	805	58.00
59.00	05900	CARDIAC CATHETERIZATION	490,738	2,225	18,106	2,225	59.00
60.00	06000	LABORATORY	4,309,017	13,081	0	13,081	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	167,618	65	0	65	62.00
64.00	06400	INTRAVENOUS THERAPY	590,089	4,529	10,107	4,529	64.00
65.00	06500	RESPIRATORY THERAPY	1,074,153	2,179	0	2,179	65.00
66.00	06600	PHYSICAL THERAPY	1,343,400	4,016	0	4,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,828	3,288	0	3,288	67.00
68.00	06800	SPEECH PATHOLOGY	305,620	3,071	0	3,071	68.00
69.00	06900	ELECTROCARDIOLOGY	396,935	3,029	0	3,029	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	405,305	4,212	380	4,212	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,829,635	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,774,505	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,099,227	5,508	0	5,508	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	540,014	9,279	0	9,279	76.03
76.04	03952	PAIN CLINIC	77,856	507	0	507	76.04
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,960,295	13,126	0	13,126	88.00
91.00	09100	EMERGENCY	3,485,435	13,205	67,471	13,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				902	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,012,185	215,866	291,348	207,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,174	912	0	912	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	283,421	32,835	0	32,835	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	EMS	93,266	156	0	156	193.01
193.02	19302	FUND DEVELOPMENT	659,866	0	0	0	193.02
194.00	07950	UNUSED SPACE	931,673	253,344	0	0	194.00
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)	20,129,931	5,233,674	325,804	2,012,445	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.304922	10.402582	1.118264	8.337214	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,304,755	237,807	11,094	61,354	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019764	0.472671	0.038078	0.254179	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (PURCHASE R EQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	31,177					11.00
13.00	01300	NURSING ADMINISTRATION	1,346	201,137				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,475,681			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	401	0	302	395,236,937		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	11,637	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,868	53,828	201,409	10,799,838	9,953	30.00
31.00	03100	INTENSIVE CARE UNIT	1,888	25,298	130,318	5,222,449	1,684	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,350	48,437	0	36,666,623	0	50.00
51.00	05100	RECOVERY ROOM	389	5,938	28,256	5,310,875	0	51.00
53.00	05300	ANESTHESIOLOGY	10	0	64,397	3,800,572	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,812	1,720	162,945	38,057,107	0	54.00
57.00	05700	CT SCAN	408	114	86,910	44,245,454	0	57.00
58.00	05800	MRI	201	0	25,651	5,712,395	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	581	6,104	0	7,667,095	0	59.00
60.00	06000	LABORATORY	2,567	801	126,635	44,025,219	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,402,943	0	62.00
64.00	06400	INTRAVENOUS THERAPY	961	6,910	69,262	5,560,650	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,001	0	126,070	6,506,111	0	65.00
66.00	06600	PHYSICAL THERAPY	1,066	0	8,130	8,103,837	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	297	0	550	2,005,428	0	67.00
68.00	06800	SPEECH PATHOLOGY	251	0	149	825,501	0	68.00
69.00	06900	ELECTROCARDIOLOGY	308	2,349	3,914	14,237,840	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	218	0	4,352	5,420,105	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	83,596	7,030,117	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,237,265	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	968	0	13,882	84,987,880	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	574	0	590	824,003	0	76.03
76.04	03952	PAIN CLINIC	126	0	1,787	110,141	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,333	13,564	32,949	7,508,314	0	88.00
91.00	09100	EMERGENCY	3,253	35,487	303,237	37,969,175	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,177	200,550	1,475,291	395,236,937	11,637	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	EMS	0	0	390	0	0	193.01
193.02	19302	FUND DEVELOPMENT	0	587	0	0	0	193.02
194.00	07950	UNUSED SPACE	0	0	0	0	0	194.00
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)	1,607,462	3,437,285	624,187	535,754	1,079,011	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	51.559226	17.089272	0.422982	0.001356	92.722437	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	125,311	148,375	33,111	21,125	16,642	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.019341	0.737681	0.022438	0.000053	1.430094	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	9,663,111		9,663,111	0	9,663,111	30.00	
31.00	03100	INTENSIVE CARE UNIT	5,080,488		5,080,488	0	5,080,488	31.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,530,733		6,530,733	0	6,530,733	50.00	
51.00	05100	RECOVERY ROOM	780,147		780,147	0	780,147	51.00	
53.00	05300	ANESTHESIOLOGY	194,658		194,658	0	194,658	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,570,567		6,570,567	0	6,570,567	54.00	
57.00	05700	CT SCAN	959,599		959,599	0	959,599	57.00	
58.00	05800	MRI	292,099		292,099	0	292,099	58.00	
59.00	05900	CARDIAC CATHETERIZATION	846,984		846,984	0	846,984	59.00	
60.00	06000	LABORATORY	6,127,370		6,127,370	0	6,127,370	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	221,848		221,848	0	221,848	62.00	
64.00	06400	INTRAVENOUS THERAPY	1,070,666		1,070,666	0	1,070,666	64.00	
65.00	06500	RESPIRATORY THERAPY	1,556,278	0	1,556,278	0	1,556,278	65.00	
66.00	06600	PHYSICAL THERAPY	1,897,681	0	1,897,681	0	1,897,681	66.00	
67.00	06700	OCCUPATIONAL THERAPY	562,479	0	562,479	0	562,479	67.00	
68.00	06800	SPEECH PATHOLOGY	470,483	0	470,483	0	470,483	68.00	
69.00	06900	ELECTROCARDIOLOGY	651,717		651,717	0	651,717	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	628,679		628,679	0	628,679	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,432,424		2,432,424	0	2,432,424	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,330,829		2,330,829	0	2,330,829	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	17,367,548		17,367,548	0	17,367,548	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0		0	0	0	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	909,525		909,525	0	909,525	76.03	
76.04	03952	PAIN CLINIC	118,498		118,498	0	118,498	76.04	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	7,146,540		7,146,540	0	7,146,540	88.00	
91.00	09100	EMERGENCY	5,834,520		5,834,520	0	5,834,520	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	793,970		793,970		793,970	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	81,039,441	0	81,039,441	0	81,039,441	200.00	
201.00		Less Observation Beds	793,970		793,970		793,970	201.00	
202.00		Total (see instructions)	80,245,471	0	80,245,471	0	80,245,471	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0052		Period: From 10/01/2020 To 09/30/2021		Worksheet C Part I Date/Time Prepared: 2/25/2022 2:44 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS						9.00	10.00		
30.00	03000	ADULTS & PEDIATRICS	9,794,130		9,794,130			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,222,449		5,222,449			31.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,001,048	28,665,575	36,666,623	0.178111	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,369,558	3,941,317	5,310,875	0.146896	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	1,000,899	2,799,673	3,800,572	0.051218	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,300,606	33,756,501	38,057,107	0.172650	0.000000	54.00	
57.00	05700	CT SCAN	11,485,022	32,760,432	44,245,454	0.021688	0.000000	57.00	
58.00	05800	MRI	1,293,055	4,419,340	5,712,395	0.051134	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	3,571,312	4,095,783	7,667,095	0.110470	0.000000	59.00	
60.00	06000	LABORATORY	15,338,422	28,686,797	44,025,219	0.139179	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	930,388	472,555	1,402,943	0.158130	0.000000	62.00	
64.00	06400	INTRAVENOUS THERAPY	28,101	5,532,549	5,560,650	0.192543	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	4,265,851	2,240,260	6,506,111	0.239202	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	743,378	7,360,459	8,103,837	0.234171	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	789,065	1,216,363	2,005,428	0.280478	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	269,125	556,376	825,501	0.569936	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	4,822,327	9,415,513	14,237,840	0.045774	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	138,431	5,281,674	5,420,105	0.115990	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,904,002	4,126,115	7,030,117	0.346001	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,018,063	8,219,202	11,237,265	0.207420	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	14,311,475	70,676,405	84,987,880	0.204353	0.000000	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0.000000	0.000000	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	824,003	824,003	1.103788	0.000000	76.03	
76.04	03952	PAIN CLINIC	4,068	106,073	110,141	1.075875	0.000000	76.04	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	7,508,314	7,508,314			88.00	
91.00	09100	EMERGENCY	7,421,484	30,547,691	37,969,175	0.153665	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	355,653	650,055	1,005,708	0.789464	0.000000	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	101,377,912	293,859,025	395,236,937			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	101,377,912	293,859,025	395,236,937			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2020
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.178111			50.00
51.00	05100	RECOVERY ROOM	0.146896			51.00
53.00	05300	ANESTHESIOLOGY	0.051218			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172650			54.00
57.00	05700	CT SCAN	0.021688			57.00
58.00	05800	MRI	0.051134			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110470			59.00
60.00	06000	LABORATORY	0.139179			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.158130			62.00
64.00	06400	INTRAVENOUS THERAPY	0.192543			64.00
65.00	06500	RESPIRATORY THERAPY	0.239202			65.00
66.00	06600	PHYSICAL THERAPY	0.234171			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280478			67.00
68.00	06800	SPEECH PATHOLOGY	0.569936			68.00
69.00	06900	ELECTROCARDIOLOGY	0.045774			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115990			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.346001			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207420			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204353			73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000			76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.103788			76.03
76.04	03952	PAIN CLINIC	1.075875			76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.153665			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.789464			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,663,111		9,663,111	0	9,663,111	30.00
31.00	03100	INTENSIVE CARE UNIT	5,080,488		5,080,488	0	5,080,488	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,530,733		6,530,733	0	6,530,733	50.00
51.00	05100	RECOVERY ROOM	780,147		780,147	0	780,147	51.00
53.00	05300	ANESTHESIOLOGY	194,658		194,658	0	194,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,570,567		6,570,567	0	6,570,567	54.00
57.00	05700	CT SCAN	959,599		959,599	0	959,599	57.00
58.00	05800	MRI	292,099		292,099	0	292,099	58.00
59.00	05900	CARDIAC CATHETERIZATION	846,984		846,984	0	846,984	59.00
60.00	06000	LABORATORY	6,127,370		6,127,370	0	6,127,370	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	221,848		221,848	0	221,848	62.00
64.00	06400	INTRAVENOUS THERAPY	1,070,666		1,070,666	0	1,070,666	64.00
65.00	06500	RESPIRATORY THERAPY	1,556,278	0	1,556,278	0	1,556,278	65.00
66.00	06600	PHYSICAL THERAPY	1,897,681	0	1,897,681	0	1,897,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	562,479	0	562,479	0	562,479	67.00
68.00	06800	SPEECH PATHOLOGY	470,483	0	470,483	0	470,483	68.00
69.00	06900	ELECTROCARDIOLOGY	651,717		651,717	0	651,717	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	628,679		628,679	0	628,679	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,432,424		2,432,424	0	2,432,424	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,330,829		2,330,829	0	2,330,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,367,548		17,367,548	0	17,367,548	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0		0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	909,525		909,525	0	909,525	76.03
76.04	03952	PAIN CLINIC	118,498		118,498	0	118,498	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,146,540		7,146,540	0	7,146,540	88.00
91.00	09100	EMERGENCY	5,834,520		5,834,520	0	5,834,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	793,970		793,970		793,970	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	81,039,441	0	81,039,441	0	81,039,441	200.00
201.00		Less Observation Beds	793,970		793,970		793,970	201.00
202.00		Total (see instructions)	80,245,471	0	80,245,471	0	80,245,471	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0052		Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/25/2022 2:44 pm	
				Title XIX			Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,794,130		9,794,130			30.00
31.00	03100	INTENSIVE CARE UNIT	5,222,449		5,222,449			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,001,048	28,665,575	36,666,623	0.178111	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,369,558	3,941,317	5,310,875	0.146896	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,000,899	2,799,673	3,800,572	0.051218	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,300,606	33,756,501	38,057,107	0.172650	0.000000	54.00
57.00	05700	CT SCAN	11,485,022	32,760,432	44,245,454	0.021688	0.000000	57.00
58.00	05800	MRI	1,293,055	4,419,340	5,712,395	0.051134	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,571,312	4,095,783	7,667,095	0.110470	0.000000	59.00
60.00	06000	LABORATORY	15,338,422	28,686,797	44,025,219	0.139179	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	930,388	472,555	1,402,943	0.158130	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	28,101	5,532,549	5,560,650	0.192543	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,265,851	2,240,260	6,506,111	0.239202	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	743,378	7,360,459	8,103,837	0.234171	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	789,065	1,216,363	2,005,428	0.280478	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	269,125	556,376	825,501	0.569936	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,822,327	9,415,513	14,237,840	0.045774	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	138,431	5,281,674	5,420,105	0.115990	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,904,002	4,126,115	7,030,117	0.346001	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,018,063	8,219,202	11,237,265	0.207420	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,311,475	70,676,405	84,987,880	0.204353	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0.000000	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	824,003	824,003	1.103788	0.000000	76.03
76.04	03952	PAIN CLINIC	4,068	106,073	110,141	1.075875	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	7,508,314	7,508,314	0.951817	0.000000	88.00
91.00	09100	EMERGENCY	7,421,484	30,547,691	37,969,175	0.153665	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	355,653	650,055	1,005,708	0.789464	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	101,377,912	293,859,025	395,236,937			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	101,377,912	293,859,025	395,236,937			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000			76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.03
76.04	03952	PAIN CLINIC	0.000000			76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	509,431	0	509,431	10,844	46.98	30.00
31.00	INTENSIVE CARE UNIT	294,534		294,534	1,684	174.90	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
200.00	Total (lines 30 through 199)	803,965		803,965	12,528		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	3,448	161,987				30.00
31.00	INTENSIVE CARE UNIT	716	125,228				31.00
41.00	SUBPROVIDER - IRF	0	0				41.00
200.00	Total (lines 30 through 199)	4,164	287,215				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		725,894	36,666,623	0.019797	3,679,632	72,846	50.00
51.00	05100	RECOVERY ROOM		36,526	5,310,875	0.006878	0	0	51.00
53.00	05300	ANESTHESIOLOGY		46,867	3,800,572	0.012332	455,628	5,619	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		686,703	38,057,107	0.018044	1,911,317	34,488	54.00
57.00	05700	CT SCAN		29,613	44,245,454	0.000669	4,770,228	3,191	57.00
58.00	05800	MRI		9,046	5,712,395	0.001584	462,952	733	58.00
59.00	05900	CARDIAC CATHETERIZATION		43,709	7,667,095	0.005701	1,233,792	7,034	59.00
60.00	06000	LABORATORY		239,959	44,025,219	0.005450	6,551,052	35,703	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		5,218	1,402,943	0.003719	351,593	1,308	62.00
64.00	06400	INTRAVENOUS THERAPY		72,074	5,560,650	0.012961	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		70,086	6,506,111	0.010772	1,664,916	17,934	65.00
66.00	06600	PHYSICAL THERAPY		200,299	8,103,837	0.024717	351,233	8,681	66.00
67.00	06700	OCCUPATIONAL THERAPY		51,150	2,005,428	0.025506	369,316	9,420	67.00
68.00	06800	SPEECH PATHOLOGY		41,554	825,501	0.050338	142,881	7,192	68.00
69.00	06900	ELECTROCARDIOLOGY		69,695	14,237,840	0.004895	2,020,088	9,888	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		30,290	5,420,105	0.005588	47,970	268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		39,074	7,030,117	0.005558	1,156,241	6,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		36,311	11,237,265	0.003231	1,277,430	4,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		350,898	84,987,880	0.004129	5,428,579	22,415	73.00
76.00	03950	THERAPEUTIC ACTIVITIES		0	0	0.000000	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		54,895	824,003	0.066620	0	0	76.03
76.04	03952	PAIN CLINIC		8,435	110,141	0.076584	0	0	76.04
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC		644,830	7,508,314	0.085882	0	0	88.00
91.00	09100	EMERGENCY		214,850	37,969,175	0.005659	3,198,202	18,099	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		41,857	1,005,708	0.041619	208,305	8,669	92.00
200.00		Total (lines 50 through 199)		3,749,833	380,220,358		35,281,355	274,041	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part III
Date/Time Prepared:
2/25/2022 2:44 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	10,844	0.00	3,448	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,684	0.00	716	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
200.00		Total (lines 30 through 199)		0	12,528		4,164	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						
41.00	04100	SUBPROVIDER - IRF	0						
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.03
76.04	03952	PAIN CLINIC	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 2:44 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	36,666,623	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,310,875	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,800,572	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,057,107	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	44,245,454	0.000000	57.00
58.00	05800	MRI	0	0	0	5,712,395	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,667,095	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,025,219	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,402,943	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,560,650	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,506,111	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,103,837	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,005,428	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	825,501	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,237,840	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,420,105	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,030,117	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,237,265	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,987,880	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	824,003	0.000000	76.03
76.04	03952	PAIN CLINIC	0	0	0	110,141	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,508,314	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	37,969,175	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,005,708	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	380,220,358		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/25/2022 2:44 pm

				Title XVIII		Hospital	PPS		
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	3,679,632	0	6,406,270	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	1,294,938	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.000000	455,628	0	709,388	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,911,317	0	10,943,311	0	54.00	
57.00	05700	CT SCAN	0.000000	4,770,228	0	7,693,678	0	57.00	
58.00	05800	MRI	0.000000	462,952	0	1,066,200	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,233,792	0	1,146,221	0	59.00	
60.00	06000	LABORATORY	0.000000	6,551,052	0	3,628,441	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	351,593	0	137,779	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	795,317	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	1,664,916	0	612,908	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	351,233	0	29,727	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	369,316	0	5,218	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	142,881	0	3,930	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,020,088	0	2,673,292	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	47,970	0	1,107,453	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,156,241	0	1,006,642	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,277,430	0	2,096,980	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,428,579	0	33,008,732	0	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	100,057	0	76.03	
76.04	03952	PAIN CLINIC	0.000000	0	0	11,587	0	76.04	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
91.00	09100	EMERGENCY	0.000000	3,198,202	0	5,439,790	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	208,305	0	175,095	0	92.00	
200.00		Total (lines 50 through 199)		35,281,355	0	80,092,954	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/25/2022 2:44 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.178111	6,406,270	0	0	1,141,027	50.00
51.00	05100	RECOVERY ROOM	0.146896	1,294,938	0	0	190,221	51.00
53.00	05300	ANESTHESIOLOGY	0.051218	709,388	0	0	36,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172650	10,943,311	0	0	1,889,363	54.00
57.00	05700	CT SCAN	0.021688	7,693,678	0	0	166,860	57.00
58.00	05800	MRI	0.051134	1,066,200	0	0	54,519	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110470	1,146,221	0	0	126,623	59.00
60.00	06000	LABORATORY	0.139179	3,628,441	1,800	0	505,003	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.158130	137,779	0	0	21,787	62.00
64.00	06400	INTRAVENOUS THERAPY	0.192543	795,317	0	0	153,133	64.00
65.00	06500	RESPIRATORY THERAPY	0.239202	612,908	0	0	146,609	65.00
66.00	06600	PHYSICAL THERAPY	0.234171	29,727	0	0	6,961	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280478	5,218	0	0	1,464	67.00
68.00	06800	SPEECH PATHOLOGY	0.569936	3,930	0	0	2,240	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045774	2,673,292	0	0	122,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115990	1,107,453	0	0	128,453	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.346001	1,006,642	0	0	348,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207420	2,096,980	0	0	434,956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204353	33,008,732	0	8,763	6,745,433	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.103788	100,057	0	0	110,442	76.03
76.04	03952	PAIN CLINIC	1.075875	11,587	0	0	12,466	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.153665	5,439,790	0	0	835,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.789464	175,095	0	0	138,231	92.00
200.00		Subtotal (see instructions)		80,092,954	1,800	8,763	13,318,695	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		80,092,954	1,800	8,763	13,318,695	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/25/2022 2:44 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	251	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,791		73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0		76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.03
76.04	03952	PAIN CLINIC	0	0		76.04
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	251	1,791		200.00
201.00		Less PBP Clinic Lab. Services-Program	0			201.00
		Only Charges				
202.00		Net Charges (line 200 - line 201)	251	1,791		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0052

Period:

Worksheet D

Component CCN: 14-T052

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/25/2022 2:44 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	725,894	36,666,623	0.019797	0	0	50.00
51.00	05100	RECOVERY ROOM	36,526	5,310,875	0.006878	0	0	51.00
53.00	05300	ANESTHESIOLOGY	46,867	3,800,572	0.012332	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	686,703	38,057,107	0.018044	0	0	54.00
57.00	05700	CT SCAN	29,613	44,245,454	0.000669	0	0	57.00
58.00	05800	MRI	9,046	5,712,395	0.001584	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	43,709	7,667,095	0.005701	0	0	59.00
60.00	06000	LABORATORY	239,959	44,025,219	0.005450	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,218	1,402,943	0.003719	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	72,074	5,560,650	0.012961	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	70,086	6,506,111	0.010772	0	0	65.00
66.00	06600	PHYSICAL THERAPY	200,299	8,103,837	0.024717	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,150	2,005,428	0.025506	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	41,554	825,501	0.050338	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,695	14,237,840	0.004895	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,290	5,420,105	0.005588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,074	7,030,117	0.005558	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,311	11,237,265	0.003231	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,898	84,987,880	0.004129	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0.000000	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	54,895	824,003	0.066620	0	0	76.03
76.04	03952	PAIN CLINIC	8,435	110,141	0.076584	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	644,830	7,508,314	0.085882	0	0	88.00
91.00	09100	EMERGENCY	214,850	37,969,175	0.005659	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,005,708	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,707,976	380,220,358		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0052 Component CCN: 14-T052		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/25/2022 2:44 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES		0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.03
76.04	03952	PAIN CLINIC		0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0052 Component CCN: 14-T052		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/25/2022 2:44 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	36,666,623	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,310,875	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,800,572	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,057,107	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	44,245,454	0.000000	57.00
58.00	05800	MRI	0	0	0	5,712,395	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,667,095	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,025,219	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,402,943	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,560,650	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,506,111	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,103,837	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,005,428	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	825,501	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,237,840	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,420,105	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,030,117	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,237,265	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,987,880	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	824,003	0.000000	76.03
76.04	03952	PAIN CLINIC	0	0	0	110,141	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,508,314	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	37,969,175	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,005,708	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	380,220,358		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0052 Component CCN: 14-T052		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/25/2022 2:44 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES		0.000000	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.03
76.04	03952	PAIN CLINIC		0.000000	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/25/2022 2:44 pm	
Title XVIII		Hospital		PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			10,844	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			10,844	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			9,953	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3,448	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			9,663,111	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			9,663,111	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			9,663,111	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)			891.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,072,513	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,072,513	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Title XVIII		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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,080,488	1,684	3,016.92	716	2,160,115	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)					5,433,324	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,665,952	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)					287,215	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					274,041	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					561,256	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,104,696	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)					891	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					891.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					793,970	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	509,431	9,663,111	0.052719	793,970	41,857
91.00	Nursing Program cost	0	9,663,111	0.000000	793,970	0
92.00	Allied health cost	0	9,663,111	0.000000	793,970	0
93.00	All other Medical Education	0	9,663,111	0.000000	793,970	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052 Component CCN: 14-T052	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/25/2022 2:44 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		0	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)		0	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)		0	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1	
				Component CCN: 14-T052		Date/Time Prepared: 2/25/2022 2:44 pm	
				Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0052 Component CCN: 14-T052		Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/25/2022 2:44 pm	
			Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/25/2022 2:44 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		3,595,928		30.00
31.00	03100	INTENSIVE CARE UNIT		2,013,408		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.178111	3,679,632	655,383	50.00
51.00	05100	RECOVERY ROOM	0.146896	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.051218	455,628	23,336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172650	1,911,317	329,989	54.00
57.00	05700	CT SCAN	0.021688	4,770,228	103,457	57.00
58.00	05800	MRI	0.051134	462,952	23,673	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110470	1,233,792	136,297	59.00
60.00	06000	LABORATORY	0.139179	6,551,052	911,769	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.158130	351,593	55,597	62.00
64.00	06400	INTRAVENOUS THERAPY	0.192543	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.239202	1,664,916	398,251	65.00
66.00	06600	PHYSICAL THERAPY	0.234171	351,233	82,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280478	369,316	103,585	67.00
68.00	06800	SPEECH PATHOLOGY	0.569936	142,881	81,433	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045774	2,020,088	92,468	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.115990	47,970	5,564	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.346001	1,156,241	400,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207420	1,277,430	264,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204353	5,428,579	1,109,346	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.103788	0	0	76.03
76.04	03952	PAIN CLINIC	1.075875	0	0	76.04
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.153665	3,198,202	491,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.789464	208,305	164,449	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,281,355	5,433,324	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)		35,281,355		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A
Date/Time Prepared:
2/25/2022 2:44 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			9,212,864	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			66,682	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)			46.56	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.16	30.00
31.00	Percentage of Medicaid patient days (see instructions)			14.49	31.00
32.00	Sum of lines 30 and 31			19.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)			7.45	33.00
34.00	Disproportionate share adjustment (see instructions)			171,590	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/25/2022 2:44 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	822,212	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	822,212	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		822,212		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (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 (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)		10,273,348		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			10,273,348	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			699,408	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			51,279	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			11,024,035	59.00
60.00	Primary payer payments			5,691	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			11,018,344	61.00
62.00	Deductibles billed to program beneficiaries			1,005,640	62.00
63.00	Coinsurance billed to program beneficiaries			5,936	63.00
64.00	Allowable bad debts (see instructions)			280,841	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			182,547	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			286,249	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10,189,315	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			38,086	70.93
70.94	HRR adjustment amount (see instructions)			-71,334	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/25/2022 2:44 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,156,067	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		10,118,093	72.00	
72.01	Interim payments-PARHM		0	72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		37,974	74.00	
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		930,909	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/25/2022 2:44 pm

		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	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,212,864	0	0	9,212,864	9,212,864
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	66,682	0	0	66,682	66,682
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	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	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	0.0745	0.0745	0.0745	0.0745	0.0745
11.00	Disproportionate share adjustment (see instructions)	34.00	171,590	0	0	171,590	171,590
11.01	Uncompensated care payments	36.00	822,212	0	0	822,212	822,212
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	10,273,348	0	0	10,273,348	10,273,348
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,273,348	0	0	10,273,348	10,273,348
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	699,408	0	0	699,408	699,408

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/25/2022 2:44 pm

				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	51,279	0	0	51,279	51,279	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	0	11,024,035	11,024,035	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	694,525	0	0	694,525	694,525	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	4,883	0	0	4,883	4,883	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	699,408	0	0	699,408	699,408	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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/25/2022 2:44 pm

		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	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,212,864		9,212,864	9,212,864	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	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	66,682		66,682	66,682	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	0.0745	0.0745	0.0745		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	171,590	0	171,590	171,590	11.00
11.01	Uncompensated care payments	36.00	822,212	0	822,212	822,212	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	10,273,348	0	10,273,348	10,273,348	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,273,348	0	10,273,348	10,273,348	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	699,408	0	699,408	699,408	16.00
17.00	Special add-on payments for new technologies	54.00	51,279	0	51,279	51,279	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			0	11,024,035	11,024,035	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/25/2022 2:44 pm

		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	694,525	0	694,525	694,525	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	4,883	0	4,883	4,883	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	699,408	0	699,408	699,408	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	38,086	0	38,086	38,086	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-71,334	0	-71,334	-71,334	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/25/2022 2:44 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,042
2.00	Medical and other services reimbursed under OPPS (see instructions)			13,318,695
3.00	OPPS payments			10,739,311
4.00	Outlier payment (see instructions)			0
4.01	Outlier reconciliation amount (see instructions)			0
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000
6.00	Line 2 times line 5			0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00
8.00	Transitional corridor payment (see instructions)			0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0
10.00	Organ acquisitions			0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,042
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			10,563
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0
14.00	Total reasonable charges (sum of lines 12 and 13)			10,563
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0
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
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000
18.00	Total customary charges (see instructions)			10,563
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			8,521
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0
21.00	Lesser of cost or charges (see instructions)			2,042
22.00	Interns and residents (see instructions)			0
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			10,739,311
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,914,965
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			8,826,388
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0
30.00	Subtotal (sum of lines 27 through 29)			8,826,388
31.00	Primary payer payments			3,700
32.00	Subtotal (line 30 minus line 31)			8,822,688
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0
34.00	Allowable bad debts (see instructions)			289,298
35.00	Adjusted reimbursable bad debts (see instructions)			188,044
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			289,298
37.00	Subtotal (see instructions)			9,010,732
38.00	MSP-LCC reconciliation amount from PS&R			0
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
39.97	Demonstration payment adjustment amount before sequestration			0
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0
40.00	Subtotal (see instructions)			9,010,732
40.01	Sequestration adjustment (see instructions)			0
40.02	Demonstration payment adjustment amount after sequestration			0
40.03	Sequestration adjustment-PARHM pass-throughs			0
41.00	Interim payments			9,071,334
41.01	Interim payments-PARHM			0
42.00	Tentative settlement (for contractors use only)			0
42.01	Tentative settlement-PARHM (for contractor use only)			0
43.00	Balance due provider/program (see instructions)			-60,602
43.01	Balance due provider/program-PARHM (see instructions)			0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			584,312
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0
91.00	Outlier reconciliation adjustment amount (see instructions)			0
92.00	The rate used to calculate the Time Value of Money			0.00
93.00	Time Value of Money (see instructions)			0
94.00	Total (sum of lines 91 and 93)			0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/25/2022 2:44 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,118,093		9,071,334	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)		10,118,093		9,071,334	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		37,974		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		60,602	6.02
7.00	Total Medicare program liability (see instructions)		10,156,067		9,010,732	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: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/25/2022 2:44 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052 Component CCN: 14-T052	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part III Date/Time Prepared: 2/25/2022 2:44 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			0 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			0 3.00
4.00	Outlier Payments			0 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			0.000000 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			0 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			0 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			0 19.00
20.00	Deductibles			0 20.00
21.00	Subtotal (line 19 minus line 20)			0 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			0 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			0 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			0 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			0 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			0 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			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

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

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/25/2022 2:44 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	0	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	49,762,979	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-38,776,748	0	0	0	6.00
7.00 Inventory	3,066,913	0	0	0	7.00
8.00 Prepaid expenses	105,884	0	0	0	8.00
9.00 Other current assets	1,360,112	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)	15,519,140	0	0	0	11.00
FIXED ASSETS					
12.00 Land	1,080,000	0	0	0	12.00
13.00 Land improvements	9,095,258	0	0	0	13.00
14.00 Accumulated depreciation	-8,450,151	0	0	0	14.00
15.00 Buildings	65,558,095	0	0	0	15.00
16.00 Accumulated depreciation	-46,218,022	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	34,210,101	0	0	0	23.00
24.00 Accumulated depreciation	-23,294,470	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	5,059,407	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	37,040,218	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	181,519	2,660,814	31,050	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	6,885,303	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	7,066,822	2,660,814	31,050	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	59,626,180	2,660,814	31,050	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	3,161,569	0	0	0	37.00
38.00 Salaries, wages, and fees payable	221,163	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	101,555,034	0	0	0	40.00
41.00 Deferred income	144,713	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	9,040,555	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	114,123,034	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	41,207,888	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	41,207,888	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	155,330,922	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	-95,704,742				52.00
53.00 Specific purpose fund		2,660,814			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			31,050		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)	-95,704,742	2,660,814	31,050	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	59,626,180	2,660,814	31,050	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/25/2022 2:44 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-93,115,005		2,660,814		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,811,493				2.00
3.00	Total (sum of line 1 and line 2)		-98,926,498		2,660,814		3.00
4.00	OTHER CHANGES	173,010		0		0	4.00
5.00	PENSION ADJUSTMENT	9,472,244		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)		9,645,254		0		10.00
11.00	Subtotal (line 3 plus line 10)		-89,281,244		2,660,814		11.00
12.00	EQUITY TRANSFER (OSFMG)	323,894		0		0	12.00
13.00	EQUITY TRANSFER	6,099,604		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)		6,423,498		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-95,704,742		2,660,814		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	31,050		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)	31,050		0			3.00
4.00	OTHER CHANGES		0				4.00
5.00	PENSION ADJUSTMENT		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)	31,050		0			11.00
12.00	EQUITY TRANSFER (OSFMG)		0				12.00
13.00	EQUITY TRANSFER		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)	31,050		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2022 2:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,039,132		9,039,132	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,039,132		9,039,132	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,222,449		5,222,449	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)	5,222,449		5,222,449	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,261,581		14,261,581	17.00
18.00	Ancillary services	87,048,001	285,778,763	372,826,764	18.00
19.00	Outpatient services	4,068	930,076	934,144	19.00
20.00	RURAL HEALTH CLINIC	0	7,508,314	7,508,314	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	13,096	788,942	802,038	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	101,326,746	295,006,095	396,332,841	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		93,788,500		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		93,788,500		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0052

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/25/2022 2:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	396,332,841	1.00
2.00	Less contractual allowances and discounts on patients' accounts	310,005,645	2.00
3.00	Net patient revenues (line 1 minus line 2)	86,327,196	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	93,788,500	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,461,304	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	865,815	6.00
7.00	Income from investments	27,376	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	328,323	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	-2,602	17.00
18.00	Revenue from sale of medical records and abstracts	275	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	22,325	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	240,178	24.00
24.01	BLUE CROSS QUALITY / RISK RESERVES	562,912	24.01
24.02	FINANCE CHARGES	65,161	24.02
24.50	COVID-19 PHE Funding	710,699	24.50
25.00	Total other income (sum of lines 6-24)	2,820,462	25.00
26.00	Total (line 5 plus line 25)	-4,640,842	26.00
27.00	PENSION COST	1,170,651	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,170,651	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,811,493	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0052	Period: From 10/01/2020 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 2/25/2022 2:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		694,525	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,883	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)		31.88	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)		699,408	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

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0052

Period:

Worksheet M-1

Component CCN: 14-8612

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 2:44 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	653,709	0	653,709	0	653,709
2.00	Physician Assistant	157,202	0	157,202	5,352	162,554
3.00	Nurse Practitioner	974,986	0	974,986	33,193	1,008,179
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	9,979	0	9,979	340	10,319
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	793,672	0	793,672	32,774	826,446
10.00	Subtotal (sum of lines 1 through 9)	2,589,548	0	2,589,548	71,659	2,661,207
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	32,949	32,949	0	32,949
16.00	Transportation (Health Care Staff)	0	3,092	3,092	0	3,092
17.00	Depreciation-Medical Equipment	0	485	485	0	485
18.00	Professional Liability Insurance	0	8,969	8,969	0	8,969
19.00	Other Health Care Costs	0	181,949	181,949	0	181,949
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	227,444	227,444	0	227,444
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,589,548	227,444	2,816,992	71,659	2,888,651
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	136,105	136,105	0	136,105
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	136,105	136,105	0	136,105
FACILITY OVERHEAD						
29.00	Facility Costs	0	661,596	661,596	0	661,596
30.00	Administrative Costs	169,007	742,203	911,210	-219,542	691,668
31.00	Total Facility Overhead (sum of lines 29 and 30)	169,007	1,403,799	1,572,806	-219,542	1,353,264
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,758,555	1,767,348	4,525,903	-147,883	4,378,020

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0052

Period:

Worksheet M-1

Component CCN: 14-8612

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 2:44 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	653,709	1.00
2.00	Physician Assistant	0	162,554	2.00
3.00	Nurse Practitioner	0	1,008,179	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	10,319	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	826,446	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,661,207	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	32,949	15.00
16.00	Transportation (Health Care Staff)	0	3,092	16.00
17.00	Depreciation-Medical Equipment	0	485	17.00
18.00	Professional Liability Insurance	0	8,969	18.00
19.00	Other Health Care Costs	0	181,949	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	227,444	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,888,651	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	136,105	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	136,105	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	661,596	29.00
30.00	Administrative Costs	-20,104	671,564	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-20,104	1,333,160	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-20,104	4,357,916	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0052

Period:

Worksheet M-2

Component CCN: 14-8612

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 2:44 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.91	6,075	4,200	8,022		1.00
2.00	Physician Assistant	1.25	3,710	2,100	2,625		2.00
3.00	Nurse Practitioner	9.94	13,193	2,100	20,874		3.00
4.00	Subtotal (sum of lines 1 through 3)	13.10	22,978		31,521	31,521	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	13.10	22,978			31,521	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,888,651	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					136,105	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,024,756	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.955003	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,333,160	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,788,624	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,121,784	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,121,784	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,936,316	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,824,967	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0052 Component CCN: 14-8612	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/25/2022 2:44 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,824,967	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			338,001	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,486,966	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			31,521	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			31,521	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			205.80	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	250.73	8.00
9.00	Rate for Program covered visits (see instructions)	205.80	205.80	205.80	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	971	927	2,050	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	199,832	190,777	421,890	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	812,499		16.00
16.01	Total program charges (see instructions)(from contractor's records)		933,685		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		33,082		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		28,788		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		532,806		16.04
16.05	Total program cost (see instructions)	0	561,594		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		117,703		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		156,580		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		561,594		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		97,896		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		659,490		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		659,490		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		582,380		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		77,110		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0052

Period:

Worksheet M-4

Component CCN: 14-8612

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/25/2022 2:44 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,661,207	2,661,207	2,661,207	2,661,207	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002254	0.008328	0.008328	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,998	22,163	22,163	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	67,394	25,341	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	73,392	47,504	22,163	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,888,651	2,888,651	2,888,651	2,888,651	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,936,316	3,936,316	3,936,316	3,936,316	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.025407	0.016445	0.007672	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	100,010	64,733	30,199	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	173,402	112,237	52,362	0	10.00
11.00	Total number of injections/infusions (from your records)	443	1,637	3,139	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	391.43	68.56	16.68	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	80	360	1,411	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			1,101	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	31,314	24,682	41,900	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		338,001			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		97,896			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0052 Component CCN: 14-8612	Period: From 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/25/2022 2:44 pm
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		582,380	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		582,380	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		77,110	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		659,490	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00