

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: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 8:29 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/28/2022	Time: 8:29 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PASSAVANT AREA HOSPITAL (14-0058) 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	Paul Eddington	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Paul Eddington		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-62,239	-30,454	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
7.00 SKILLED NURSING FACILITY	0	0	341		0	7.00
200.00 Total	0	-62,239	-30,113	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: 14-0058		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 8:29 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1600 WEST WALNUT			PO Box:				1.00		
2.00	City: JACKSONVILLE			State: IL		Zip Code: 62650-1185		County: MORGAN		
		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		PASSAVANT AREA HOSPITAL	140058	99914	1	07/01/1966	N	P	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2020		09/30/2021	
21.00	Type of Control (see instructions)						2			
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
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)					N	N	N		22.03
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									
22.04	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)					N	N	N		22.04
23.00	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.									
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 8:29 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	266	7	0	0	1,359	16	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		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.					10/01/2020	09/30/2021	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)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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.					N		
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		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 8:29 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 8:29 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	742,954	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0058		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 8:29 am					
1.00		2.00		3.00									
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.													
141.00	Name: MEMORIAL HEALTH SYSTEMS		Contractor's Name: MEMORIAL HEALTH SYSTEMS		Contractor's Number: 00131		141.00						
142.00	Street: 701 NORTH FIRST STREET		PO Box:				142.00						
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62781		143.00						
								1.00					
144.00 Are provider based physicians' costs included in Worksheet A?								Y		144.00			
								1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00					
								1.00					
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N		147.00			
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N		148.00			
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N		149.00			
				Part A		Part B		Title V		Title XIX			
				1.00		2.00		3.00		4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)													
155.00	Hospital			N		N		N		N	155.00		
156.00	Subprovider - IPF			N		N		N		N	156.00		
157.00	Subprovider - IRF			N		N		N		N	157.00		
158.00	SUBPROVIDER										158.00		
159.00	SNF			N		N		N		N	159.00		
160.00	HOME HEALTH AGENCY			N		N		N		N	160.00		
161.00	CMHC			N		N		N		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)								0.00		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: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 8:29 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/17/2021
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		
			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	01/07/2022	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/28/2022 8:29 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0058

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.	SIGNING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 8:29 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	97	35,405	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)		97	35,405	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		106	38,690	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	15	5,475		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		121			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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 8:29 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,416	151	6,918			1.00
2.00	HMO and other (see instructions)	766	1,359				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)	3,416	151	6,918			7.00
8.00	INTENSIVE CARE UNIT	522	48	1,401			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		74	613			13.00
14.00	Total (see instructions)	3,938	273	8,932	0.00	568.24	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,171	0	3,140	0.00	18.22	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	586.46	27.00
28.00	Observation Bed Days		355	1,784			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			107			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	16	136			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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 8:29 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,070	378	2,392	1.00
2.00 HMO and other (see instructions)			200	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,070	378	2,392	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 8:29 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	37,918,033	0	37,918,033	1,150,180.81	32.97
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	800	0	800	4.00	200.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B	547,114	0	547,114	3,719.08	147.11	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,081,128	0	1,081,128	36,332.73	29.76
10.00	Excluded area salaries (see instructions)		330,277	0	330,277	12,616.92	26.18
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,535,076	0	1,535,076	16,378.75	93.72
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		238,947	0	238,947	1,679.75	142.25
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		1,862,205	0	1,862,205	33,104.76	56.25
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,038,169	0	8,038,169		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		338,316	0	338,316		
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		80	0	80		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		59,576	0	59,576		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		257,542	0	257,542		
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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 8:29 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	651,912	0	651,912	16,167.07	40.32	26.00
27.00	Administrative & General	5.00	6,773,361	0	6,773,361	157,206.97	43.09	27.00
28.00	Administrative & General under contract (see inst.)		25,340	0	25,340	96.05	263.82	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,702,674	0	1,702,674	74,734.12	22.78	30.00
31.00	Laundry & Linen Service	8.00	229,487	0	229,487	13,599.47	16.87	31.00
32.00	Housekeeping	9.00	1,093,215	0	1,093,215	66,440.69	16.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,155,217	-986,853	168,364	9,884.59	17.03	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	986,853	986,853	57,937.62	17.03	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	643,182	0	643,182	15,810.65	40.68	38.00
39.00	Central Services and Supply	14.00	206,891	0	206,891	11,341.53	18.24	39.00
40.00	Pharmacy	15.00	1,081,649	-1,081,649	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	761,663	0	761,663	30,617.87	24.88	41.00
42.00	Social Service	17.00	280,345	0	280,345	8,075.01	34.72	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/28/2022 8:29 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	37,396,259	0	37,396,259	1,146,557.78	32.62	1.00
2.00	Excluded area salaries (see instructions)	1,411,405	0	1,411,405	48,949.65	28.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)	35,984,854	0	35,984,854	1,097,608.13	32.78	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,636,228	0	3,636,228	51,163.26	71.07	4.00
5.00	Subtotal wage-related costs (see inst.)	8,295,791	0	8,295,791	0.00	23.05	5.00
6.00	Total (sum of lines 3 thru 5)	47,916,873	0	47,916,873	1,148,771.39	41.71	6.00
7.00	Total overhead cost (see instructions)	14,604,936	-1,081,649	13,523,287	461,911.64	29.28	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
2/28/2022 8:29 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	172,502	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	18,804	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)	5,745,174	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)	14,840	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)	63,400	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	197,102	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,870,799	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-664,004	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	17,525	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,436,142	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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,535,076	8,436,142	1.00
2.00	Hospital	1,535,076	8,195,609	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	240,533	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/28/2022 8:29 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.200516 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,539,405		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,036,803		5.00
6.00	Medicaid charges	85,449,146		6.00
7.00	Medicaid cost (line 1 times line 6)	17,133,921		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	8,557,713		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	132,654		9.00
10.00	Stand-alone CHIP charges	565,024		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	113,296		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,557,713		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)	3,472,901	435,652	3,908,553 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	696,372	435,652	1,132,024 21.00
22.00	Payments received from patients for amounts previously written off as charity care	205,984	14,060	220,044 22.00
23.00	Cost of charity care (line 21 minus line 22)	490,388	421,592	911,980 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)	4,561,793		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	560,207		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	861,857		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,699,936		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,043,546		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,955,526		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,513,239		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0058

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

Worksheet A

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,812,223	1,812,223	345,018	2,157,241	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,678,158	1,678,158	24,726	1,702,884	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	651,912	8,274,028	8,925,940	-6	8,925,934	4.00
5.01	00540	NONPATIENT TELEPHONES	0	142,872	142,872	0	142,872	5.01
5.02	00550	DATA PROCESSING	769,813	1,937,210	2,707,023	0	2,707,023	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	65,369	151,774	217,143	0	217,143	5.03
5.04	00570	ADMITTING	588,102	47,243	635,345	0	635,345	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	585,172	881,497	1,466,669	0	1,466,669	5.05
5.06	00590	OTHER ADMIN & GENERAL	4,764,905	15,124,589	19,889,494	-731,361	19,158,133	5.06
7.00	00700	OPERATION OF PLANT	1,702,674	2,857,317	4,559,991	0	4,559,991	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	229,487	101,052	330,539	0	330,539	8.00
9.00	00900	HOUSEKEEPING	1,093,215	281,261	1,374,476	0	1,374,476	9.00
10.00	01000	DIETARY	1,155,217	1,171,315	2,326,532	-1,987,458	339,074	10.00
11.00	01100	CAFETERIA	0	0	0	1,987,458	1,987,458	11.00
13.00	01300	NURSING ADMINISTRATION	643,182	79,861	723,043	0	723,043	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	206,891	55,397	262,288	-19,831	242,457	14.00
15.00	01500	PHARMACY	1,081,649	4,424,322	5,505,971	-5,208,986	296,985	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	761,663	44,363	806,026	0	806,026	16.00
17.00	01700	SOCIAL SERVICE	280,345	7,028	287,373	0	287,373	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-84,563	0	-84,563	84,563	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,911,007	1,020,614	4,931,621	-778,749	4,152,872	30.00
31.00	03100	INTENSIVE CARE UNIT	974,227	403,091	1,377,318	-6,489	1,370,829	31.00
40.00	04000	SUBPROVIDER - IPF	0	46	46	-46	0	40.00
43.00	04300	NURSERY	0	0	0	416,749	416,749	43.00
44.00	04400	SKILLED NURSING FACILITY	1,081,128	115,498	1,196,626	-264	1,196,362	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,417,946	3,507,426	5,925,372	-2,509,754	3,415,618	50.00
51.00	05100	RECOVERY ROOM	254,674	15,162	269,836	-468	269,368	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	452,892	452,892	52.00
53.00	05300	ANESTHESIOLOGY	0	272,718	272,718	-53,044	219,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,465,680	401,811	1,867,491	-12,148	1,855,343	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	270,224	67,886	338,110	-83	338,027	55.00
56.00	05600	RADIOISOTOPE	107,555	185,634	293,189	-108	293,081	56.00
57.00	05700	CT SCAN	487,291	366,911	854,202	-8,623	845,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	304,180	124,967	429,147	-135	429,012	58.00
60.00	06000	LABORATORY	1,717,057	2,910,164	4,627,221	-40	4,627,181	60.00
65.00	06500	RESPIRATORY THERAPY	971,906	256,377	1,228,283	-158,207	1,070,076	65.00
66.00	06600	PHYSICAL THERAPY	3,066,025	197,205	3,263,230	-214	3,263,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	973,368	47,010	1,020,378	-3,361	1,017,017	67.00
68.00	06800	SPEECH PATHOLOGY	299,795	5,687	305,482	0	305,482	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	132	0	132	-132	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,005,028	2,005,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,136,052	1,136,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,850,203	5,850,203	73.00
74.00	07400	RENAL DIALYSIS	140,156	21,491	161,647	-16,952	144,695	74.00
76.00	03950	DIABETIC EDUCATION	240,679	8,550	249,229	0	249,229	76.00
76.97	07697	CARDIAC REHABILITATION	88,299	4,474	92,773	0	92,773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	85,096	30,603	115,699	0	115,699	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,656,752	1,060,233	2,716,985	-279,407	2,437,578	90.00
91.00	09100	EMERGENCY	2,579,546	3,560,094	6,139,640	-225,573	5,914,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		301,250	301,250	-301,250	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,587,756	53,956,412	91,544,168	0	91,544,168	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	185,488	97,670	283,158	0	283,158	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	80,382	45,466	125,848	0	125,848	194.02
194.03	07953	HEALTHY JACKSONVILLE	64,407	7,826	72,233	0	72,233	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	37,918,033	54,107,374	92,025,407	0	92,025,407	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0058

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

Worksheet A

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	649,386	2,806,627	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,831,263	3,534,147	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-208,797	8,717,137	4.00
5.01	00540	NONPATIENT TELEPHONES	-5,532	137,340	5.01
5.02	00550	DATA PROCESSING	0	2,707,023	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	217,143	5.03
5.04	00570	ADMITTING	0	635,345	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-31,941	1,434,728	5.05
5.06	00590	OTHER ADMIN & GENERAL	-8,637,234	10,520,899	5.06
7.00	00700	OPERATION OF PLANT	-44,396	4,515,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,539	8.00
9.00	00900	HOUSEKEEPING	0	1,374,476	9.00
10.00	01000	DIETARY	-102,879	236,195	10.00
11.00	01100	CAFETERIA	-375,159	1,612,299	11.00
13.00	01300	NURSING ADMINISTRATION	-2,082	720,961	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-146	242,311	14.00
15.00	01500	PHARMACY	-600	296,385	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,280	789,746	16.00
17.00	01700	SOCIAL SERVICE	0	287,373	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-138,852	4,014,020	30.00
31.00	03100	INTENSIVE CARE UNIT	-30,475	1,340,354	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	416,749	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,196,362	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,100	3,414,518	50.00
51.00	05100	RECOVERY ROOM	0	269,368	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	452,892	52.00
53.00	05300	ANESTHESIOLOGY	0	219,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,762	1,853,581	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	338,027	55.00
56.00	05600	RADIOISOTOPE	0	293,081	56.00
57.00	05700	CT SCAN	0	845,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	429,012	58.00
60.00	06000	LABORATORY	0	4,627,181	60.00
65.00	06500	RESPIRATORY THERAPY	-5,699	1,064,377	65.00
66.00	06600	PHYSICAL THERAPY	-66,104	3,196,912	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,017,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	305,482	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,005,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,136,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-10,413	5,839,790	73.00
74.00	07400	RENAL DIALYSIS	-9,197	135,498	74.00
76.00	03950	DIABETIC EDUCATION	0	249,229	76.00
76.97	07697	CARDIAC REHABILITATION	0	92,773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	115,699	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,169,682	1,267,896	90.00
91.00	09100	EMERGENCY	-2,247,594	3,666,473	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)	-10,625,275	80,918,893	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	283,158	192.00
194.00	07950	RENTED SPACE	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	125,848	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	72,233	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,625,275	81,400,132	200.00

RECLASSIFICATIONS

Provider CCN: 14-0058

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 8:29 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	301,250		1.00
2.00		0.00	0	0		2.00
			0	301,250		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	68,494		1.00
	TOTALS		0	68,494		
	C - DRUGS SOLD TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,770,316		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	0		0	4,770,316		
	D - MEDICAL SUPPLIES & IMPLANTS SOLD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,005,028		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,136,052		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	3,141,080		
	E - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	986,853	1,000,605		1.00
	0		986,853	1,000,605		
	F - PHARMACY SALARIES					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,081,649	0		1.00
	TOTALS		1,081,649	0		
	G - RN AND AIDE WAGES					
1.00	ANESTHESIOLOGY	53.00	75,243	0		1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	159,806	0		2.00
	TOTALS		235,049	0		
	H - NURSERY & L&D					
1.00	NURSERY	43.00	366,775	49,974		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	398,584	54,308		2.00
	TOTALS		765,359	104,282		
	I - CLOSED DEPARTMENTS					
1.00	OTHER ADMIN & GENERAL	5.06	0	46		1.00
	TOTALS		0	46		
	J - EEG					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	132	0		1.00
	TOTALS		132	0		
	K - MEDICAL DIRECTORS					
1.00	ADULTS & PEDIATRICS	30.00	0	101,166		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	990		2.00
3.00	RESPIRATORY THERAPY	65.00	0	8,973		3.00
4.00	RENAL DIALYSIS	74.00	0	18,348		4.00
	TOTALS		0	129,477		

RECLASSIFICATIONS

Provider CCN: 14-0058

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

Worksheet A-6

Date/Time Prepared:
2/28/2022 8:29 am

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
500.00	Grand Total: Increases	3,069,042	9,515,550			500.00

RECLASSIFICATIONS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Date/Time Prepared:
2/28/2022 8:29 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	294,750	11		1.00
2.00	INTEREST EXPENSE	113.00	0	6,500	14		2.00
	0		0	301,250			
	B - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	68,494	12		1.00
	TOTALS		0	68,494			
	C - DRUGS SOLD TO PATIENTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6	0		1.00
2.00	OTHER ADMIN & GENERAL	5.06	0	533,436	0		2.00
3.00	CENTRAL SERVICE & SUPPLY	14.00	0	28	0		3.00
4.00	PHARMACY	15.00	0	4,127,337	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	4,086	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	2,489	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	0	264	0		7.00
8.00	OPERATING ROOM	50.00	0	7,057	0		8.00
9.00	RECOVERY ROOM	51.00	0	468	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	54,610	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,104	0		11.00
12.00	RADIOLOGY - THERAPEUTIC	55.00	0	83	0		12.00
13.00	RADIOISOTOPE	56.00	0	108	0		13.00
14.00	CT SCAN	57.00	0	8,623	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	135	0		15.00
16.00	LABORATORY	60.00	0	40	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	14,874	0		17.00
18.00	RENAL DIALYSIS	74.00	0	862	0		18.00
19.00	CLINIC	90.00	0	1,920	0		19.00
20.00	EMERGENCY	91.00	0	11,786	0		20.00
	0		0	4,770,316			
	D - MEDICAL SUPPLIES & IMPLANTS SOLD						
1.00	ADULTS & PEDIATRICS	30.00	0	6,188	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	4,000	0		2.00
3.00	OPERATING ROOM	50.00	0	1,395,004	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	73,677	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,609	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	152,306	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	214	0		7.00
8.00	OCCUPATIONAL THERAPY	67.00	0	3,361	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,762	0		9.00
10.00	RENAL DIALYSIS	74.00	0	34,438	0		10.00
11.00	EMERGENCY	91.00	0	213,787	0		11.00
12.00	CLINIC	90.00	0	117,681	0		12.00
13.00	OPERATING ROOM	50.00	0	1,107,693	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,557	0		14.00
15.00	CENTRAL SERVICE & SUPPLY	14.00	0	19,803	0		15.00
	TOTALS		0	3,141,080			
	E - CAFETERIA COSTS						
1.00	DIETARY	10.00	986,853	1,000,605	0		1.00
	0		986,853	1,000,605			
	F - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,081,649	0	0		1.00
	TOTALS		1,081,649	0			
	G - RN AND AIDE WAGES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	75,243	0	0		1.00
2.00	CLINIC	90.00	159,806	0	0		2.00
	TOTALS		235,049	0			
	H - NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	765,359	104,282	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		765,359	104,282			
	I - CLOSED DEPARTMENTS						
1.00	SUBPROVIDER - IPF	40.00	0	46	0		1.00
	TOTALS		0	46			
	J - EEG						
1.00	ELECTROENCEPHALOGRAPHY	70.00	132	0	0		1.00
	TOTALS		132	0			
	K - MEDICAL DIRECTORS						
1.00	OTHER ADMIN & GENERAL	5.06	0	129,477	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
	TOTALS		0	129,477			
500.00	Grand Total: Decreases		3,069,042	9,515,550			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 8:29 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	735,200	0	0	0	0	1.00	
2.00	Land Improvements	1,281,184	0	0	0	0	2.00	
3.00	Buildings and Fixtures	12,121,090	2,786,084	0	2,786,084	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	21,361,049	1,303,112	0	1,303,112	0	5.00	
6.00	Movable Equipment	23,881,190	0	0	0	1,214,809	6.00	
7.00	HIT designated Assets	753,492	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	60,133,205	4,089,196	0	4,089,196	1,214,809	8.00	
9.00	Reconciling Items	-16,751,964	-3,613,955	0	-3,613,955	0	9.00	
10.00	Total (line 8 minus line 9)	76,885,169	7,703,151	0	7,703,151	1,214,809	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	735,200	0					1.00
2.00	Land Improvements	1,281,184	0					2.00
3.00	Buildings and Fixtures	14,907,174	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	22,664,161	0					5.00
6.00	Movable Equipment	22,666,381	0					6.00
7.00	HIT designated Assets	753,492	0					7.00
8.00	Subtotal (sum of lines 1-7)	63,007,592	0					8.00
9.00	Reconciling Items	-20,365,919	0					9.00
10.00	Total (line 8 minus line 9)	83,373,511	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,812,223	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,678,158	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,490,381	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	1,812,223				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,678,158				2.00
3.00	Total (sum of lines 1-2)	0	3,490,381				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	39,587,719	0	39,587,719	0.639006	43,768	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,419,873	1,055,527	22,364,346	0.360994	24,726	2.00
3.00	Total (sum of lines 1-2)	63,007,592	1,055,527	61,952,065	1.000000	68,494	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	43,768	2,703,854	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	24,726	3,509,421	0	2.00
3.00	Total (sum of lines 1-2)	0	0	68,494	6,213,275	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	59,005	43,768	0	0	2,806,627	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	24,726	0	0	3,534,147	2.00
3.00	Total (sum of lines 1-2)	59,005	68,494	0	0	6,340,774	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-242,245	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,532	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-38,636	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,847,609			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-5,760	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	194,001			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-366,585	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	-16,280	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-8,574	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-31,941	CASHIERING/ACCOUNTS RECEIVABLE	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRUST ACCOUNT FEES	A	193,878	OTHER ADMIN & GENERAL	5.06	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0058

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

Worksheet A-8

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	DOORBELL DINNERS	B	-102,777	DIETARY	10.00	0	33.01
33.02	MISC INCOME - A&G	B	-272,238	OTHER ADMIN & GENERAL	5.06	0	33.02
33.03	MISC INCOME - NURSING ADMIN	B	-2,082	NURSING ADMINISTRATION	13.00	0	33.03
33.04	MISC INCOME - OR	B	-1,100	OPERATING ROOM	50.00	0	33.04
33.05	MISC INCOME - PT	B	-66,104	PHYSICAL THERAPY	66.00	0	33.05
33.06	MISC INCOME - CLINIC	B	-43,777	CLINIC	90.00	0	33.06
33.07	MISC INCOME - RADIOLOGY	B	-30	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	MISC INCOME - PHARMACY	B	-600	PHARMACY	15.00	0	33.08
33.09	MISC INCOME - CENTRAL SERVICE	B	-146	CENTRAL SERVICE & SUPPLY	14.00	0	33.09
33.10	MISC INCOME - DIETARY	B	-102	DIETARY	10.00	0	33.10
33.11	OTHER NONOPERATING INCOME	B	-75,011	OTHER ADMIN & GENERAL	5.06	0	33.11
34.00	ADVERTISING/MARKETING	A	-35,477	OTHER ADMIN & GENERAL	5.06	0	34.00
35.00	RETIREE HEALTH INSURANCE PLAN	A	221,772	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	LOBBYING EXPENSE	A	-24,397	OTHER ADMIN & GENERAL	5.06	0	36.00
37.00	PROVIDER TAX	A	-3,924,444	OTHER ADMIN & GENERAL	5.06	0	37.00
38.00	PHYSICIAN RECRUITMENT	A	-72,224	OTHER ADMIN & GENERAL	5.06	0	38.00
39.00	INTERMEDIARY DEPRECIATION	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
39.01	ADJUSTMENT						
39.01	REVALUED ASSETS DEPRECIATION	A	799,417	CAP REL COSTS-BLDG & FIXT	1.00	9	39.01
39.02	ADJUSTM						
39.02	REVALUED ASSETS DEPRECIATION	A	1,146,264	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.02
39.02	ADJUSTM						
40.00	EMPLOYED PHYSICIAN BENEFITS	A	-17,075	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	340B DRUGS & EXPENSES	A	-10,413	DRUGS CHARGED TO PATIENTS	73.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,625,275				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: 14-0058

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 8:29 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	60,596	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	99,125	0
3.00		1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	1,066	0
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	585,874	0
4.01		5.06	OTHER ADMIN & GENERAL	HO INTEREST OPERATING	16,461	0
4.02		5.06	OTHER ADMIN & GENERAL	HO MANAGEMENT OPERATING	3,396,447	3,552,074
4.03		4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	5,049,890	5,463,384
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				9,209,459	9,015,458

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

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

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

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 14-0058

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

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 8:29 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	60,596	9		1.00
2.00	99,125	9		2.00
3.00	1,066	9		3.00
4.00	585,874	9		4.00
4.01	16,461	0		4.01
4.02	-155,627	0		4.02
4.03	-413,494	0		4.03
5.00	194,001			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

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

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

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

6.00	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		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: 14-0058

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

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 8:29 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	OTHER ADMIN & GENERAL	4,288,155	4,288,155	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	205,963	104,797	101,166	211,500	660	2.00
3.00	31.00	INTENSIVE CARE UNIT	49,998	78	49,920	211,500	192	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	5,000	0	5,000	271,900	25	4.00
5.00	65.00	RESPIRATORY THERAPY	9,563	0	9,563	211,500	38	5.00
6.00	74.00	RENAL DIALYSIS	18,348	0	18,348	211,500	90	6.00
7.00	90.00	CLINIC	1,127,532	1,123,732	3,800	211,500	16	7.00
8.00	91.00	EMERGENCY	2,299,544	2,247,594	51,950	211,500	663	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,004,103	7,764,356	239,747		1,684	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	OTHER ADMIN & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	67,111	3,356	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	19,523	976	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	3,268	163	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	3,864	193	0	0	0	5.00
6.00	74.00	RENAL DIALYSIS	9,151	458	0	0	0	6.00
7.00	90.00	CLINIC	1,627	81	0	0	0	7.00
8.00	91.00	EMERGENCY	67,416	3,371	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			171,960	8,598	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	OTHER ADMIN & GENERAL	0	0	0	4,288,155		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	67,111	34,055	138,852		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	19,523	30,397	30,475		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	3,268	1,732	1,732		4.00
5.00	65.00	RESPIRATORY THERAPY	0	3,864	5,699	5,699		5.00
6.00	74.00	RENAL DIALYSIS	0	9,151	9,197	9,197		6.00
7.00	90.00	CLINIC	0	1,627	2,173	1,125,905		7.00
8.00	91.00	EMERGENCY	0	67,416	0	2,247,594		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	171,960	83,253	7,847,609		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,806,627	2,806,627			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,534,147	3,534,147			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,717,137	70,199	1,260	8,788,596	4.00
5.01	00540	NONPATIENT TELEPHONES	137,340	7,470	0	144,810	5.01
5.02	00550	DATA PROCESSING	2,707,023	31,205	137,662	184,238	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	217,143	78,749	0	15,645	5.03
5.04	00570	ADMITTING	635,345	7,891	1,597	140,749	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,434,728	20,454	0	140,048	5.05
5.06	00590	OTHER ADMIN & GENERAL	10,520,899	218,541	841,997	1,140,367	5.06
7.00	00700	OPERATION OF PLANT	4,515,595	397,380	67,902	407,498	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	330,539	56,690	8,309	54,923	8.00
9.00	00900	HOUSEKEEPING	1,374,476	109,399	52,811	261,637	9.00
10.00	01000	DIETARY	236,195	62,431	36,499	40,294	10.00
11.00	01100	CAFETERIA	1,612,299	48,892	0	236,182	11.00
13.00	01300	NURSING ADMINISTRATION	720,961	17,830	22,346	153,931	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	242,311	56,073	110,079	49,515	14.00
15.00	01500	PHARMACY	296,385	32,121	9,148	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	789,746	30,506	13,438	182,287	16.00
17.00	01700	SOCIAL SERVICE	287,373	5,865	0	67,094	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,014,020	315,141	162,939	727,761	30.00
31.00	03100	INTENSIVE CARE UNIT	1,340,354	47,513	59,770	233,160	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	416,749	7,994	11,961	87,780	43.00
44.00	04400	SKILLED NURSING FACILITY	1,196,362	69,500	15,805	258,744	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,414,518	168,281	414,735	578,682	50.00
51.00	05100	RECOVERY ROOM	269,368	12,130	28,375	60,951	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	452,892	16,410	12,998	95,392	52.00
53.00	05300	ANESTHESIOLOGY	219,674	10,690	164,522	18,008	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,853,581	32,903	353,013	350,810	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	338,027	13,355	552,909	64,672	55.00
56.00	05600	RADIOISOTOPE	293,081	3,087	0	25,741	56.00
57.00	05700	CT SCAN	845,579	69,633	0	116,622	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	429,012	15,886	0	72,799	58.00
60.00	06000	LABORATORY	4,627,181	78,369	118,076	410,940	60.00
65.00	06500	RESPIRATORY THERAPY	1,064,377	38,932	114,110	232,604	65.00
66.00	06600	PHYSICAL THERAPY	3,196,912	152,755	22,113	733,786	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,017,017	44,673	1,735	232,954	67.00
68.00	06800	SPEECH PATHOLOGY	305,482	3,220	2,157	71,749	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,005,028	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,136,052	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,839,790	0	0	258,869	73.00
74.00	07400	RENAL DIALYSIS	135,498	8,066	9,842	33,543	74.00
76.00	03950	DIABETIC EDUCATION	249,229	0	0	57,601	76.00
76.97	07697	CARDIAC REHABILITATION	92,773	30,537	10,301	21,132	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	115,699	7,058	399	20,366	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,267,896	60,610	41,948	253,120	90.00
91.00	09100	EMERGENCY	3,666,473	185,144	129,902	617,358	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)	80,918,893	2,643,583	3,530,658	8,709,552	140,298
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	13,252	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	283,158	0	3,489	44,392	192.00
194.00	07950	RENTED SPACE	0	141,201	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	125,848	8,591	0	19,238	194.02
194.03	07953	HEALTHY JACKSONVILLE	72,233	0	0	15,414	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	81,400,132	2,806,627	3,534,147	8,788,596	144,810

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	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	00550	DATA PROCESSING	3,070,170					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	34,840	347,978				5.03
5.04	00570	ADMITTING	209,367	12,648	1,011,235			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	209,367	8,821	0	1,816,474		5.05
5.06	00590	OTHER ADMIN & GENERAL	209,367	31,518	0	0	12,975,642	5.06
7.00	00700	OPERATION OF PLANT	0	13,380	0	0	5,409,032	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,735	0	0	462,069	8.00
9.00	00900	HOUSEKEEPING	0	39,786	0	0	1,839,273	9.00
10.00	01000	DIETARY	104,683	96,177	0	0	578,899	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,897,373	11.00
13.00	01300	NURSING ADMINISTRATION	348,891	8,596	0	0	1,278,959	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	965	0	0	459,525	14.00
15.00	01500	PHARMACY	69,843	10,808	0	0	420,197	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,524	1,456	0	0	1,159,140	16.00
17.00	01700	SOCIAL SERVICE	34,840	2,346	0	0	400,283	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,843	10,238	48,928	87,871	5,446,492	30.00
31.00	03100	INTENSIVE CARE UNIT	209,367	3,114	20,723	37,217	1,955,002	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	795	3,446	6,188	535,932	43.00
44.00	04400	SKILLED NURSING FACILITY	69,843	3,571	12,103	21,736	1,649,847	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,840	33,315	90,814	163,094	4,915,164	50.00
51.00	05100	RECOVERY ROOM	0	1,485	7,143	12,829	392,281	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	864	3,979	7,147	590,701	52.00
53.00	05300	ANESTHESIOLOGY	0	811	11,349	20,382	449,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	348,890	2,976	72,222	129,704	3,151,521	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	238	34,385	61,752	1,067,084	55.00
56.00	05600	RADIOISOTOPE	0	1	11,165	20,052	353,127	56.00
57.00	05700	CT SCAN	0	607	177,513	319,179	1,529,133	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	39	39,981	71,803	629,520	58.00
60.00	06000	LABORATORY	174,364	7,872	129,947	233,374	5,786,963	60.00
65.00	06500	RESPIRATORY THERAPY	104,683	3,397	57,467	103,206	1,721,541	65.00
66.00	06600	PHYSICAL THERAPY	279,047	5,541	68,275	122,616	4,590,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,510	21,693	38,958	1,359,850	67.00
68.00	06800	SPEECH PATHOLOGY	0	37	4,523	8,122	395,290	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,607	24,437	2,043,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,254	13,028	1,156,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73,972	132,848	6,305,479	73.00
74.00	07400	RENAL DIALYSIS	0	2,612	3,397	6,101	199,059	74.00
76.00	03950	DIABETIC EDUCATION	0	663	92	165	307,750	76.00
76.97	07697	CARDIAC REHABILITATION	0	596	1,342	2,411	159,674	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	53	3,283	5,895	152,753	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,077	29,813	53,541	1,716,244	90.00
91.00	09100	EMERGENCY	279,047	13,140	62,819	112,818	5,076,743	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)	2,930,646	334,788	1,011,235	1,816,474	80,516,090	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	13,252	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	371	0	0	335,485	192.00
194.00	07950	RENTED SPACE	0	0	0	0	141,201	194.00
194.01	07951	PASSAVANT FOUNDATION	139,524	0	0	0	139,524	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	11,285	0	0	165,399	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	1,534	0	0	89,181	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,070,170	347,978	1,011,235	1,816,474	81,400,132	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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2/28/2022 8:29 am

Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	12,975,642					5.06
7.00	00700	OPERATION OF PLANT	1,025,736	6,434,768				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,624	184,728	734,421			8.00
9.00	00900	HOUSEKEEPING	348,789	356,481	4,188	2,548,731		9.00
10.00	01000	DIETARY	109,779	203,435	3,124	70,310	965,547	10.00
11.00	01100	CAFETERIA	359,806	159,315	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	242,534	58,100	0	70,310	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	87,142	182,716	0	4,960	0	14.00
15.00	01500	PHARMACY	79,684	104,668	0	52,732	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,812	99,404	0	22,538	0	16.00
17.00	01700	SOCIAL SERVICE	75,907	19,110	0	4,960	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,032,840	1,026,901	151,855	546,827	605,431	30.00
31.00	03100	INTENSIVE CARE UNIT	370,735	154,823	15,782	70,310	53,670	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	101,631	26,050	3,193	20,419	0	43.00
44.00	04400	SKILLED NURSING FACILITY	312,867	226,468	85,325	123,042	211,383	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	932,082	548,350	143,640	251,093	95,063	50.00
51.00	05100	RECOVERY ROOM	74,390	39,527	11,059	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	112,017	53,474	3,469	22,201	0	52.00
53.00	05300	ANESTHESIOLOGY	85,160	34,833	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	597,636	107,216	85,481	107,247	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	202,355	43,517	3,152	50,276	0	55.00
56.00	05600	RADIOISOTOPE	66,965	10,058	0	0	0	56.00
57.00	05700	CT SCAN	289,976	226,904	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	119,378	51,764	0	0	0	58.00
60.00	06000	LABORATORY	1,097,405	255,367	448	77,485	0	60.00
65.00	06500	RESPIRATORY THERAPY	326,463	126,862	3,381	50,324	0	65.00
66.00	06600	PHYSICAL THERAPY	870,433	497,760	58,057	187,332	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	257,874	145,570	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	74,960	10,494	0	38,189	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	387,436	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,280	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,195,766	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	37,748	26,284	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	58,360	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	30,280	99,505	203	26,535	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	28,967	22,999	907	18,974	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	325,458	197,501	119	120,586	0	90.00
91.00	09100	EMERGENCY	962,723	603,299	156,144	596,911	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)	12,807,998	5,903,483	729,527	2,533,561	965,547	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,513	43,181	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	63,619	0	4,894	15,170	0	192.00
194.00	07950	RENTED SPACE	26,777	460,110	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	26,458	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	31,365	27,994	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	16,912	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,975,642	6,434,768	734,421	2,548,731	965,547	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	2,416,494					11.00
13.00	01300	NURSING ADMINISTRATION	48,579	1,698,482				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	34,938	0	769,281			14.00
15.00	01500	PHARMACY	0	0	0	657,281		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,894	0	0	0	1,594,788	16.00
17.00	01700	SOCIAL SERVICE	24,333	36,952	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	314,272	444,928	0	0	77,154	30.00
31.00	03100	INTENSIVE CARE UNIT	84,812	115,390	0	0	32,678	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	26,476	38,274	0	0	5,433	43.00
44.00	04400	SKILLED NURSING FACILITY	114,474	166,261	0	0	19,085	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	243,111	332,866	0	0	143,203	50.00
51.00	05100	RECOVERY ROOM	16,784	24,798	0	0	11,264	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,782	41,592	0	0	6,275	52.00
53.00	05300	ANESTHESIOLOGY	8,452	0	0	0	17,896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,825	0	0	0	113,885	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	23,115	0	0	0	54,221	55.00
56.00	05600	RADIOISOTOPE	8,202	0	0	0	17,606	56.00
57.00	05700	CT SCAN	45,511	0	0	0	280,107	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,411	0	0	0	63,046	58.00
60.00	06000	LABORATORY	194,195	0	0	0	204,911	60.00
65.00	06500	RESPIRATORY THERAPY	95,091	138,302	0	0	90,619	65.00
66.00	06600	PHYSICAL THERAPY	235,334	0	0	0	107,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,440	0	0	0	34,207	67.00
68.00	06800	SPEECH PATHOLOGY	17,806	0	0	0	7,132	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	491,051	0	21,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	278,230	0	11,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,379	0	0	657,264	116,645	73.00
74.00	07400	RENAL DIALYSIS	7,745	0	0	0	5,357	74.00
76.00	03950	DIABETIC EDUCATION	38,038	0	0	0	145	76.00
76.97	07697	CARDIAC REHABILITATION	6,983	0	0	0	2,117	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	7,592	0	0	0	5,176	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	91,730	0	0	0	47,011	90.00
91.00	09100	EMERGENCY	261,016	359,119	0	0	99,058	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)	2,371,320	1,698,482	769,281	657,264	1,594,788	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	21,113	0	0	17	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	6,777	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	5,993	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	11,291	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,416,494	1,698,482	769,281	657,281	1,594,788	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	561,545					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	321,800	0	9,968,500	0	9,968,500	30.00
31.00	03100	INTENSIVE CARE UNIT	65,169	0	2,918,371	0	2,918,371	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	28,515	0	785,923	0	785,923	43.00
44.00	04400	SKILLED NURSING FACILITY	146,061	0	3,054,813	0	3,054,813	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	7,604,572	0	7,604,572	50.00
51.00	05100	RECOVERY ROOM	0	0	570,103	0	570,103	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	858,511	0	858,511	52.00
53.00	05300	ANESTHESIOLOGY	0	0	595,415	0	595,415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,296,811	0	4,296,811	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	1,443,720	0	1,443,720	55.00
56.00	05600	RADIOISOTOPE	0	0	455,958	0	455,958	56.00
57.00	05700	CT SCAN	0	0	2,371,631	0	2,371,631	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	891,119	0	891,119	58.00
60.00	06000	LABORATORY	0	0	7,616,774	0	7,616,774	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,552,583	0	2,552,583	65.00
66.00	06600	PHYSICAL THERAPY	0	0	6,546,645	0	6,546,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,863,941	0	1,863,941	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	543,871	0	543,871	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,943,016	0	2,943,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,665,283	0	1,665,283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,347,533	0	8,347,533	73.00
74.00	07400	RENAL DIALYSIS	0	0	276,193	0	276,193	74.00
76.00	03950	DIABETIC EDUCATION	0	0	404,293	0	404,293	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	325,297	0	325,297	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	237,368	0	237,368	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	2,498,649	0	2,498,649	90.00
91.00	09100	EMERGENCY	0	0	8,115,013	0	8,115,013	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)	561,545	0	79,751,906	0	79,751,906	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	58,946	0	58,946	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	440,298	0	440,298	192.00
194.00	07950	RENTED SPACE	0	0	628,088	0	628,088	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	172,759	0	172,759	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	0	230,751	0	230,751	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	117,384	0	117,384	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	561,545	0	81,400,132	0	81,400,132	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	70,199	1,260	71,459	4.00
5.01	00540	NONPATIENT TELEPHONES	0	7,470	0	7,470	5.01
5.02	00550	DATA PROCESSING	1,842	31,205	137,662	170,709	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	60	78,749	0	78,809	5.03
5.04	00570	ADMITTING	0	7,891	1,597	9,488	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	20,454	0	20,454	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	218,541	841,997	1,060,538	5.06
7.00	00700	OPERATION OF PLANT	0	397,380	67,902	465,282	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	181,779	56,690	8,309	246,778	8.00
9.00	00900	HOUSEKEEPING	0	109,399	52,811	162,210	9.00
10.00	01000	DIETARY	0	62,431	36,499	98,930	10.00
11.00	01100	CAFETERIA	0	48,892	0	48,892	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,830	22,346	40,176	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	56,073	110,079	166,152	14.00
15.00	01500	PHARMACY	0	32,121	9,148	41,269	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	119,970	30,506	13,438	163,914	16.00
17.00	01700	SOCIAL SERVICE	0	5,865	0	5,865	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	50,106	315,141	162,939	528,186	30.00
31.00	03100	INTENSIVE CARE UNIT	28,660	47,513	59,770	135,943	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	7,994	11,961	19,955	43.00
44.00	04400	SKILLED NURSING FACILITY	22,703	69,500	15,805	108,008	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,439	168,281	414,735	594,455	50.00
51.00	05100	RECOVERY ROOM	0	12,130	28,375	40,505	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,410	12,998	29,408	52.00
53.00	05300	ANESTHESIOLOGY	2,709	10,690	164,522	177,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,903	353,013	385,916	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	13,355	552,909	566,264	55.00
56.00	05600	RADIOISOTOPE	0	3,087	0	3,087	56.00
57.00	05700	CT SCAN	0	69,633	0	69,633	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,886	0	15,886	58.00
60.00	06000	LABORATORY	1,418	78,369	118,076	197,863	60.00
65.00	06500	RESPIRATORY THERAPY	3,369	38,932	114,110	156,411	65.00
66.00	06600	PHYSICAL THERAPY	88,983	152,755	22,113	263,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	44,673	1,735	46,408	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,220	2,157	5,377	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	8,066	9,842	17,908	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	583	30,537	10,301	41,421	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	7,058	399	7,457	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	60,610	41,948	102,558	90.00
91.00	09100	EMERGENCY	21,331	185,144	129,902	336,377	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)	534,952	2,643,583	3,530,658	6,709,193	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	13,252	0	13,252	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	44,464	0	3,489	47,953	192.00
194.00	07950	RENTED SPACE	0	141,201	0	141,201	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	8,591	0	8,591	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	579,416	2,806,627	3,534,147	6,920,190	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
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	7,470					5.01
5.02	00550	DATA PROCESSING	518	172,725				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	83	1,960	80,979			5.03
5.04	00570	ADMITTING	188	11,779	2,943	25,542		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	158	11,779	2,053	0	35,583	5.05
5.06	00590	OTHER ADMIN & GENERAL	668	11,779	7,335	0	0	5.06
7.00	00700	OPERATION OF PLANT	375	0	3,114	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45	0	2,498	0	0	8.00
9.00	00900	HOUSEKEEPING	60	0	9,259	0	0	9.00
10.00	01000	DIETARY	135	5,889	22,379	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	330	19,630	2,001	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	30	0	225	0	0	14.00
15.00	01500	PHARMACY	98	3,929	2,515	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113	7,849	339	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	1,960	546	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	503	3,929	2,383	1,231	1,712	30.00
31.00	03100	INTENSIVE CARE UNIT	195	11,779	725	522	725	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	53	0	185	87	121	43.00
44.00	04400	SKILLED NURSING FACILITY	113	3,929	831	305	424	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	868	1,960	7,753	2,286	3,178	50.00
51.00	05100	RECOVERY ROOM	0	0	346	180	250	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53	0	201	100	139	52.00
53.00	05300	ANESTHESIOLOGY	188	0	189	286	397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383	19,628	692	1,818	2,528	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	90	0	55	865	1,203	55.00
56.00	05600	RADIOISOTOPE	0	0	0	281	391	56.00
57.00	05700	CT SCAN	0	0	141	4,559	6,406	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	9	1,006	1,399	58.00
60.00	06000	LABORATORY	353	9,810	1,832	3,270	4,548	60.00
65.00	06500	RESPIRATORY THERAPY	143	5,889	791	1,446	2,011	65.00
66.00	06600	PHYSICAL THERAPY	465	15,699	1,290	1,718	2,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	68	0	351	546	759	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	9	114	158	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	342	476	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	183	254	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,862	2,589	73.00
74.00	07400	RENAL DIALYSIS	0	0	608	85	119	74.00
76.00	03950	DIABETIC EDUCATION	0	0	154	2	3	76.00
76.97	07697	CARDIAC REHABILITATION	30	0	139	34	47	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	12	83	115	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	270	0	949	750	1,043	90.00
91.00	09100	EMERGENCY	518	15,699	3,058	1,581	2,199	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)	7,237	164,876	77,910	25,542	35,583	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	210	0	86	0	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	7,849	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	23	0	2,626	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	357	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,470	172,725	80,979	25,542	35,583	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	1,089,593					5.06
7.00	00700	OPERATION OF PLANT	86,133	558,217				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,358	16,025	273,151			8.00
9.00	00900	HOUSEKEEPING	29,289	30,925	1,558	235,428		9.00
10.00	01000	DIETARY	9,218	17,648	1,162	6,495	162,184	10.00
11.00	01100	CAFETERIA	30,214	13,821	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	20,366	5,040	0	6,495	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	7,317	15,851	0	458	0	14.00
15.00	01500	PHARMACY	6,691	9,080	0	4,871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,458	8,623	0	2,082	0	16.00
17.00	01700	SOCIAL SERVICE	6,374	1,658	0	458	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	86,730	89,084	56,479	50,511	101,695	30.00
31.00	03100	INTENSIVE CARE UNIT	31,131	13,431	5,870	6,495	9,015	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	8,534	2,260	1,187	1,886	0	43.00
44.00	04400	SKILLED NURSING FACILITY	26,272	19,646	31,735	11,365	35,506	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	78,269	47,569	53,424	23,194	15,968	50.00
51.00	05100	RECOVERY ROOM	6,247	3,429	4,113	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,406	4,639	1,290	2,051	0	52.00
53.00	05300	ANESTHESIOLOGY	7,151	3,022	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,185	9,301	31,793	9,906	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	16,992	3,775	1,172	4,644	0	55.00
56.00	05600	RADIOISOTOPE	5,623	873	0	0	0	56.00
57.00	05700	CT SCAN	24,350	19,684	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,024	4,491	0	0	0	58.00
60.00	06000	LABORATORY	92,152	22,153	167	7,157	0	60.00
65.00	06500	RESPIRATORY THERAPY	27,414	11,005	1,258	4,649	0	65.00
66.00	06600	PHYSICAL THERAPY	73,092	43,181	21,593	17,304	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,654	12,628	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,295	910	0	3,528	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,534	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,413	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,413	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,170	2,280	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	4,901	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,543	8,632	75	2,451	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,432	1,995	337	1,753	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	27,329	17,133	44	11,139	0	90.00
91.00	09100	EMERGENCY	80,842	52,336	58,074	55,135	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)	1,075,516	512,128	271,331	234,027	162,184	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	211	3,746	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,342	0	1,820	1,401	0	192.00
194.00	07950	RENTED SPACE	2,248	39,915	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	2,222	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	2,634	2,428	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	1,420	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,089,593	558,217	273,151	235,428	162,184	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	94,847					11.00
13.00	01300	NURSING ADMINISTRATION	1,907	97,197				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,371	0	191,807			14.00
15.00	01500	PHARMACY	0	0	0	68,453		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,685	0	0	0	206,545	16.00
17.00	01700	SOCIAL SERVICE	955	2,115	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,335	25,462	0	0	9,986	30.00
31.00	03100	INTENSIVE CARE UNIT	3,329	6,603	0	0	4,229	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,039	2,190	0	0	703	43.00
44.00	04400	SKILLED NURSING FACILITY	4,493	9,514	0	0	2,470	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,542	19,049	0	0	18,534	50.00
51.00	05100	RECOVERY ROOM	659	1,419	0	0	1,458	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,130	2,380	0	0	812	52.00
53.00	05300	ANESTHESIOLOGY	332	0	0	0	2,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,253	0	0	0	14,740	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	907	0	0	0	7,018	55.00
56.00	05600	RADIOISOTOPE	322	0	0	0	2,279	56.00
57.00	05700	CT SCAN	1,786	0	0	0	36,392	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,076	0	0	0	8,160	58.00
60.00	06000	LABORATORY	7,622	0	0	0	26,521	60.00
65.00	06500	RESPIRATORY THERAPY	3,732	7,914	0	0	11,728	65.00
66.00	06600	PHYSICAL THERAPY	9,237	0	0	0	13,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,608	0	0	0	4,427	67.00
68.00	06800	SPEECH PATHOLOGY	699	0	0	0	923	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	122,435	0	2,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	69,372	0	1,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,841	0	0	68,451	15,097	73.00
74.00	07400	RENAL DIALYSIS	304	0	0	0	693	74.00
76.00	03950	DIABETIC EDUCATION	1,493	0	0	0	19	76.00
76.97	07697	CARDIAC REHABILITATION	274	0	0	0	274	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	298	0	0	0	670	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,600	0	0	0	6,084	90.00
91.00	09100	EMERGENCY	10,245	20,551	0	0	12,821	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)	93,074	97,197	191,807	68,451	206,545	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	829	0	0	2	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	266	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	235	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	443	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,847	97,197	191,807	68,453	206,545	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	20,620					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,817		987,960	0	987,960	30.00
31.00	03100	INTENSIVE CARE UNIT	2,393		234,281	0	234,281	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	1,047		39,961	0	39,961	43.00
44.00	04400	SKILLED NURSING FACILITY	5,363		262,078	0	262,078	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		880,754	0	880,754	50.00
51.00	05100	RECOVERY ROOM	0		59,102	0	59,102	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52,385	0	52,385	52.00
53.00	05300	ANESTHESIOLOGY	0		191,948	0	191,948	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		534,995	0	534,995	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		603,511	0	603,511	55.00
56.00	05600	RADIOISOTOPE	0		13,065	0	13,065	56.00
57.00	05700	CT SCAN	0		163,899	0	163,899	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		42,643	0	42,643	58.00
60.00	06000	LABORATORY	0		376,789	0	376,789	60.00
65.00	06500	RESPIRATORY THERAPY	0		236,282	0	236,282	65.00
66.00	06600	PHYSICAL THERAPY	0		469,719	0	469,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		91,343	0	91,343	67.00
68.00	06800	SPEECH PATHOLOGY	0		18,596	0	18,596	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		158,564	0	158,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		89,702	0	89,702	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		193,358	0	193,358	73.00
74.00	07400	RENAL DIALYSIS	0		25,440	0	25,440	74.00
76.00	03950	DIABETIC EDUCATION	0		7,040	0	7,040	76.00
76.97	07697	CARDIAC REHABILITATION	0		56,092	0	56,092	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		15,318	0	15,318	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		172,957	0	172,957	90.00
91.00	09100	EMERGENCY	0		654,456	0	654,456	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)	20,620	0	6,632,238	0	6,632,238	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		17,209	0	17,209	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		58,004	0	58,004	192.00
194.00	07950	RENTED SPACE	0		183,364	0	183,364	194.00
194.01	07951	PASSAVANT FOUNDATION	0		10,337	0	10,337	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0		16,693	0	16,693	194.02
194.03	07953	HEALTHY JACKSONVILLE	0		2,345	0	2,345	194.03
200.00		Cross Foot Adjustments		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)	20,620	0	6,920,190	0	6,920,190	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	272,789				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,226,026			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,823	1,150	36,722,007		4.00
5.01	00540	NONPATIENT TELEPHONES	726	0	0	995	5.01
5.02	00550	DATA PROCESSING	3,033	125,660	769,813	69	18,946
5.03	00560	PURCHASING RECEIVING AND STORES	7,654	0	65,369	11	215
5.04	00570	ADMITTING	767	1,458	588,102	25	1,292
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	0	585,172	21	1,292
5.06	00590	OTHER ADMIN & GENERAL	21,241	768,588	4,764,905	89	1,292
7.00	00700	OPERATION OF PLANT	38,623	61,982	1,702,674	50	0
8.00	00800	LAUNDRY & LINEN SERVICE	5,510	7,585	229,487	6	0
9.00	00900	HOUSEKEEPING	10,633	48,207	1,093,215	8	0
10.00	01000	DIETARY	6,068	33,317	168,364	18	646
11.00	01100	CAFETERIA	4,752	0	986,853	0	0
13.00	01300	NURSING ADMINISTRATION	1,733	20,398	643,182	44	2,153
14.00	01400	CENTRAL SERVICE & SUPPLY	5,450	100,482	206,891	4	0
15.00	01500	PHARMACY	3,122	8,350	0	13	431
16.00	01600	MEDICAL RECORDS & LIBRARY	2,965	12,266	761,663	15	861
17.00	01700	SOCIAL SERVICE	570	0	280,345	19	215
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,630	148,733	3,040,852	67	431
31.00	03100	INTENSIVE CARE UNIT	4,618	54,559	974,227	26	1,292
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
43.00	04300	NURSERY	777	10,918	366,775	7	0
44.00	04400	SKILLED NURSING FACILITY	6,755	14,427	1,081,128	15	431
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,356	378,577	2,417,946	116	215
51.00	05100	RECOVERY ROOM	1,179	25,901	254,674	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	11,865	398,584	7	0
53.00	05300	ANESTHESIOLOGY	1,039	150,178	75,243	25	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,198	322,236	1,465,812	51	2,153
55.00	05500	RADIOLOGY - THERAPEUTIC	1,298	504,704	270,224	12	0
56.00	05600	RADIOISOTOPE	300	0	107,555	0	0
57.00	05700	CT SCAN	6,768	0	487,291	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,544	0	304,180	0	0
60.00	06000	LABORATORY	7,617	107,782	1,717,057	47	1,076
65.00	06500	RESPIRATORY THERAPY	3,784	104,161	971,906	19	646
66.00	06600	PHYSICAL THERAPY	14,847	20,185	3,066,025	62	1,722
67.00	06700	OCCUPATIONAL THERAPY	4,342	1,584	973,368	9	0
68.00	06800	SPEECH PATHOLOGY	313	1,969	299,795	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,081,649	0	0
74.00	07400	RENAL DIALYSIS	784	8,984	140,156	0	0
76.00	03950	DIABETIC EDUCATION	0	0	240,679	0	0
76.97	07697	CARDIAC REHABILITATION	2,968	9,403	88,299	4	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	686	364	85,096	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,891	38,291	1,057,628	36	0
91.00	09100	EMERGENCY	17,995	118,577	2,579,546	69	1,722
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	256,942	3,222,841	36,391,730	964	18,085
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,288	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,185	185,488	28	0
194.00	07950	RENTED SPACE	13,724	0	0	0	0
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	861
194.02	07952	COMMUNITY BENEFIT & RELATIONS	835	0	80,382	3	0
194.03	07953	HEALTHY JACKSONVILLE	0	0	64,407	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,806,627	3,534,147	8,788,596	144,810	3,070,170
203.00		Unit cost multiplier (Wkst. B, Part I)	10.288637	1.095511	0.239328	145.537688	162.048453

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
204.00		Cost to be allocated (per Wkst. B, Part II)			71,459	7,470	172,725	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001946	7.507538	9.116700	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: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	944,509					5.03
5.04	00570	ADMITTING	34,329	397,732,497				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	23,942	0	397,732,497			5.05
5.06	00590	OTHER ADMIN & GENERAL	85,549	0	0	-12,975,642	68,424,490	5.06
7.00	00700	OPERATION OF PLANT	36,317	0	0	0	5,409,032	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,139	0	0	0	462,069	8.00
9.00	00900	HOUSEKEEPING	107,989	0	0	0	1,839,273	9.00
10.00	01000	DIETARY	261,046	0	0	0	578,899	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,897,373	11.00
13.00	01300	NURSING ADMINISTRATION	23,333	0	0	0	1,278,959	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,620	0	0	0	459,525	14.00
15.00	01500	PHARMACY	29,335	0	0	0	420,197	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,951	0	0	0	1,159,140	16.00
17.00	01700	SOCIAL SERVICE	6,367	0	0	0	400,283	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,789	19,240,429	19,240,429	0	5,446,492	30.00
31.00	03100	INTENSIVE CARE UNIT	8,453	8,149,135	8,149,135	0	1,955,002	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	2,159	1,354,987	1,354,987	0	535,932	43.00
44.00	04400	SKILLED NURSING FACILITY	9,693	4,759,336	4,759,336	0	1,649,847	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	90,426	35,711,509	35,711,509	0	4,915,164	50.00
51.00	05100	RECOVERY ROOM	4,031	2,808,993	2,808,993	0	392,281	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,346	1,564,850	1,564,850	0	590,701	52.00
53.00	05300	ANESTHESIOLOGY	2,201	4,462,939	4,462,939	0	449,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,077	28,400,220	28,400,220	0	3,151,521	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	647	13,521,367	13,521,367	0	1,067,084	55.00
56.00	05600	RADIOISOTOPE	3	4,390,623	4,390,623	0	353,127	56.00
57.00	05700	CT SCAN	1,647	69,881,791	69,881,791	0	1,529,133	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107	15,722,077	15,722,077	0	629,520	58.00
60.00	06000	LABORATORY	21,368	51,099,983	51,099,983	0	5,786,963	60.00
65.00	06500	RESPIRATORY THERAPY	9,221	22,598,246	22,598,246	0	1,721,541	65.00
66.00	06600	PHYSICAL THERAPY	15,041	26,848,218	26,848,218	0	4,590,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,098	8,530,356	8,530,356	0	1,359,850	67.00
68.00	06800	SPEECH PATHOLOGY	100	1,778,429	1,778,429	0	395,290	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,350,763	5,350,763	0	2,043,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,852,590	2,852,590	0	1,156,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,088,581	29,088,581	0	6,305,479	73.00
74.00	07400	RENAL DIALYSIS	7,090	1,335,904	1,335,904	0	199,059	74.00
76.00	03950	DIABETIC EDUCATION	1,799	36,237	36,237	0	307,750	76.00
76.97	07697	CARDIAC REHABILITATION	1,618	527,852	527,852	0	159,674	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	145	1,290,886	1,290,886	0	152,753	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,066	11,723,365	11,723,365	0	1,716,244	90.00
91.00	09100	EMERGENCY	35,665	24,702,831	24,702,831	0	5,076,743	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)	908,707	397,732,497	397,732,497	-12,975,642	67,540,448	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	13,252	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,007	0	0	0	335,485	192.00
194.00	07950	RENTED SPACE	0	0	0	0	141,201	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	139,524	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	30,630	0	0	0	165,399	194.02
194.03	07953	HEALTHY JACKSONVILLE	4,165	0	0	0	89,181	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	347,978	1,011,235	1,816,474		12,975,642	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.368422	0.002543	0.004567		0.189634	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,979	25,542	35,583		1,089,593	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.085737	0.000064	0.000089		0.015924	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: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
7.00	00700	OPERATION OF PLANT	191,934				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,510	572,531			8.00
9.00	00900	HOUSEKEEPING	10,633	3,265	52,925		9.00
10.00	01000	DIETARY	6,068	2,435	1,460	41,288	10.00
11.00	01100	CAFETERIA	4,752	0	0	222,156	11.00
13.00	01300	NURSING ADMINISTRATION	1,733	0	1,460	4,466	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	5,450	0	103	3,212	14.00
15.00	01500	PHARMACY	3,122	0	1,095	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,965	0	468	8,632	16.00
17.00	01700	SOCIAL SERVICE	570	0	103	2,237	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,630	118,381	11,355	25,889	30.00
31.00	03100	INTENSIVE CARE UNIT	4,618	12,303	1,460	2,295	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	777	2,489	424	2,434	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	66,517	2,555	9,039	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,356	111,977	5,214	4,065	50.00
51.00	05100	RECOVERY ROOM	1,179	8,621	0	1,543	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	2,704	461	2,646	52.00
53.00	05300	ANESTHESIOLOGY	1,039	0	0	777	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,198	66,638	2,227	12,303	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,298	2,457	1,044	2,125	55.00
56.00	05600	RADIOISOTOPE	300	0	0	754	56.00
57.00	05700	CT SCAN	6,768	0	0	4,184	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,544	0	0	2,520	58.00
60.00	06000	LABORATORY	7,617	349	1,609	17,853	60.00
65.00	06500	RESPIRATORY THERAPY	3,784	2,636	1,045	8,742	65.00
66.00	06600	PHYSICAL THERAPY	14,847	45,259	3,890	21,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,342	0	0	6,108	67.00
68.00	06800	SPEECH PATHOLOGY	313	0	793	1,637	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,654	73.00
74.00	07400	RENAL DIALYSIS	784	0	0	712	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	3,497	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	158	551	642	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	686	707	394	698	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,891	93	2,504	0	90.00
91.00	09100	EMERGENCY	17,995	121,727	12,395	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)	176,087	568,716	52,610	41,288	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,288	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,815	315	1,941	192.00
194.00	07950	RENTED SPACE	13,724	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	623	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	835	0	0	551	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	0	1,038	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,434,768	734,421	2,548,731	965,547	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.525941	1.282762	48.157411	23.385657	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	558,217	273,151	235,428	162,184	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	2.908380	0.477094	4.448333	3.928115	0.426939	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: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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	371,168					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	3,141,080				14.00
15.00	01500	PHARMACY	0	0	4,770,437			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	397,732,497		16.00
17.00	01700	SOCIAL SERVICE	8,075	0	0	0	12,072	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	97,230	0	0	19,240,429	6,918	30.00
31.00	03100	INTENSIVE CARE UNIT	25,216	0	0	8,149,135	1,401	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	8,364	0	0	1,354,987	613	43.00
44.00	04400	SKILLED NURSING FACILITY	36,333	0	0	4,759,336	3,140	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,741	0	0	35,711,509	0	50.00
51.00	05100	RECOVERY ROOM	5,419	0	0	2,808,993	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,089	0	0	1,564,850	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,462,939	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,400,220	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	13,521,367	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,390,623	0	56.00
57.00	05700	CT SCAN	0	0	0	69,881,791	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,722,077	0	58.00
60.00	06000	LABORATORY	0	0	0	51,099,983	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,223	0	0	22,598,246	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,848,218	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,530,356	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,778,429	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,005,028	0	5,350,763	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,136,052	0	2,852,590	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,770,316	29,088,581	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,335,904	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	36,237	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	527,852	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,290,886	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,723,365	0	90.00
91.00	09100	EMERGENCY	78,478	0	0	24,702,831	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)	371,168	3,141,080	4,770,316	397,732,497	12,072	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	121	0	0	192.00
194.00	07950	RENTED SPACE	0	0	0	0	0	194.00
194.01	07951	PASSAVANT FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	0	0	0	0	0	194.02
194.03	07953	HEALTHY JACKSONVILLE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,698,482	769,281	657,281	1,594,788	561,545	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.576046	0.244910	0.137782	0.004010	46.516319	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,197	191,807	68,453	206,545	20,620	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.261868	0.061064	0.014349	0.000519	1.708085	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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet B-1
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	OTHER ADMIN & GENERAL	5.06
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 SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	DIABETIC EDUCATION	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07950	RENTED SPACE	194.00
194.01	07951	PASSAVANT FOUNDATION	194.01
194.02	07952	COMMUNITY BENEFIT & RELATIONS	194.02
194.03	07953	HEALTHY JACKSONVILLE	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0058

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

Worksheet B-1

Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		19.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	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

Worksheet C
Part I
Date/Time Prepared:

MCRIF32 - 17.2.173.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 8:29 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,004,817		16,004,817			30.00
31.00	03100	INTENSIVE CARE UNIT	8,149,135		8,149,135			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	1,354,987		1,354,987			43.00
44.00	04400	SKILLED NURSING FACILITY	4,759,336		4,759,336			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,087,628	27,623,881	35,711,509	0.212945	0.000000	50.00
51.00	05100	RECOVERY ROOM	755,371	2,053,622	2,808,993	0.202956	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,096,744	468,106	1,564,850	0.548622	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,152,780	3,310,159	4,462,939	0.133413	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,079,852	26,320,368	28,400,220	0.151295	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	4,686	13,516,681	13,521,367	0.106773	0.000000	55.00
56.00	05600	RADIOISOTOPE	146,114	4,244,509	4,390,623	0.103848	0.000000	56.00
57.00	05700	CT SCAN	6,059,846	63,821,945	69,881,791	0.033938	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	640,447	15,081,630	15,722,077	0.056679	0.000000	58.00
60.00	06000	LABORATORY	15,613,152	35,486,831	51,099,983	0.149056	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,963,277	13,634,969	22,598,246	0.112955	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,486,952	24,361,266	26,848,218	0.243839	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,009,529	6,520,827	8,530,356	0.218507	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	360,281	1,418,148	1,778,429	0.305815	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,048,687	3,302,076	5,350,763	0.550018	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,053,935	1,798,655	2,852,590	0.583779	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,144,293	17,944,288	29,088,581	0.286969	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,335,904	0	1,335,904	0.206746	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	36,237	36,237	11.156911	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	527,852	527,852	0.616266	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,290,886	1,290,886	0.183880	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,842,124	9,881,241	11,723,365	0.213134	0.000000	90.00
91.00	09100	EMERGENCY	4,502,050	20,200,781	24,702,831	0.328505	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	559,511	2,676,101	3,235,612	0.633765	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	102,211,438	295,521,059	397,732,497			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	102,211,438	295,521,059	397,732,497			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.212945		50.00
51.00	05100	RECOVERY ROOM	0.202956		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548622		52.00
53.00	05300	ANESTHESIOLOGY	0.133413		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151356		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.106773		55.00
56.00	05600	RADIOISOTOPE	0.103848		56.00
57.00	05700	CT SCAN	0.033938		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056679		58.00
60.00	06000	LABORATORY	0.149056		60.00
65.00	06500	RESPIRATORY THERAPY	0.113207		65.00
66.00	06600	PHYSICAL THERAPY	0.243839		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.218507		67.00
68.00	06800	SPEECH PATHOLOGY	0.305815		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.550018		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.583779		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.286969		73.00
74.00	07400	RENAL DIALYSIS	0.213631		74.00
76.00	03950	DIABETIC EDUCATION	11.156911		76.00
76.97	07697	CARDIAC REHABILITATION	0.616266		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.183880		76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.213319		90.00
91.00	09100	EMERGENCY	0.328505		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633765		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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 8:29 am

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	987,960	0	987,960	8,702	113.53	30.00	
31.00	INTENSIVE CARE UNIT	234,281		234,281	1,401	167.22	31.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
43.00	NURSERY	39,961		39,961	613	65.19	43.00	
44.00	SKILLED NURSING FACILITY	262,078		262,078	3,140	83.46	44.00	
200.00	Total (lines 30 through 199)	1,524,280		1,524,280	13,856		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	3,416	387,818					30.00
31.00	INTENSIVE CARE UNIT	522	87,289					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	2,171	181,192					44.00
200.00	Total (lines 30 through 199)	6,109	656,299					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 8:29 am

				Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	880,754	35,711,509	0.024663	3,205,940	79,068	50.00	
51.00	05100	RECOVERY ROOM	59,102	2,808,993	0.021040	328,687	6,916	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,385	1,564,850	0.033476	4,948	166	52.00	
53.00	05300	ANESTHESIOLOGY	191,948	4,462,939	0.043009	420,192	18,072	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	534,995	28,400,220	0.018838	1,537,647	28,966	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	603,511	13,521,367	0.044634	4,686	209	55.00	
56.00	05600	RADIOISOTOPE	13,065	4,390,623	0.002976	92,990	277	56.00	
57.00	05700	CT SCAN	163,899	69,881,791	0.002345	5,981,056	14,026	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	42,643	15,722,077	0.002712	280,647	761	58.00	
60.00	06000	LABORATORY	376,789	51,099,983	0.007374	7,894,869	58,217	60.00	
65.00	06500	RESPIRATORY THERAPY	236,282	22,598,246	0.010456	4,765,137	49,824	65.00	
66.00	06600	PHYSICAL THERAPY	469,719	26,848,218	0.017495	686,917	12,018	66.00	
67.00	06700	OCCUPATIONAL THERAPY	91,343	8,530,356	0.010708	538,328	5,764	67.00	
68.00	06800	SPEECH PATHOLOGY	18,596	1,778,429	0.010456	200,136	2,093	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,564	5,350,763	0.029634	898,373	26,622	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,702	2,852,590	0.031446	538,482	16,933	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	193,358	29,088,581	0.006647	4,503,581	29,935	73.00	
74.00	07400	RENAL DIALYSIS	25,440	1,335,904	0.019043	710,456	13,529	74.00	
76.00	03950	DIABETIC EDUCATION	7,040	36,237	0.194277	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	56,092	527,852	0.106265	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	15,318	1,290,886	0.011866	0	0	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	172,957	11,723,365	0.014753	917,973	13,543	90.00	
91.00	09100	EMERGENCY	654,456	24,702,831	0.026493	2,211,364	58,586	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,542	3,235,612	0.062598	295,603	18,504	92.00	
200.00	Total (lines 50 through 199)		5,310,500	367,464,222		36,018,012	454,029	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0058		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/28/2022 8:29 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	8,702	0.00	3,416	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	1,401	0.00	522	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00		
43.00	04300	NURSERY		0	613	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		0	3,140	0.00	2,171	44.00		
200.00		Total (lines 30 through 199)		0	13,856		6,109	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0058		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 8:29 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	35,711,509	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,808,993	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,564,850	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,462,939	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,400,220	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	13,521,367	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,390,623	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	69,881,791	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,722,077	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	51,099,983	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,598,246	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,848,218	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,530,356	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,778,429	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,350,763	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,852,590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,088,581	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,335,904	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	36,237	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	527,852	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,290,886	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,723,365	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,702,831	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,235,612	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	367,464,222		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part IV Date/Time Prepared: 2/28/2022 8:29 am	
Cost Center Description				Title XVIII		Hospital	PPS	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000		3,205,940	0	7,512,979	0
51.00	05100	RECOVERY ROOM	0.000000		328,687	0	360,597	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		4,948	0	542	0
53.00	05300	ANESTHESIOLOGY	0.000000		420,192	0	827,811	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		1,537,647	0	6,662,647	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		4,686	0	5,484,187	0
56.00	05600	RADIOISOTOPE	0.000000		92,990	0	1,951,239	0
57.00	05700	CT SCAN	0.000000		5,981,056	0	19,964,276	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		280,647	0	4,403,276	0
60.00	06000	LABORATORY	0.000000		7,894,869	0	6,902,583	0
65.00	06500	RESPIRATORY THERAPY	0.000000		4,765,137	0	3,941,709	0
66.00	06600	PHYSICAL THERAPY	0.000000		686,917	0	113,280	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000		538,328	0	69,905	0
68.00	06800	SPEECH PATHOLOGY	0.000000		200,136	0	13,509	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		898,373	0	804,086	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		538,482	0	785,255	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		4,503,581	0	6,245,331	0
74.00	07400	RENAL DIALYSIS	0.000000		710,456	0	0	0
76.00	03950	DIABETIC EDUCATION	0.000000		0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	231,803	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	781,245	0
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000		917,973	0	3,602,381	0
91.00	09100	EMERGENCY	0.000000		2,211,364	0	5,270,863	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		295,603	0	1,006,355	0
200.00		Total (lines 50 through 199)			36,018,012	0	76,935,859	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0058		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 2/28/2022 8:29 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.212945	7,512,979	0	0	1,599,851	50.00
51.00	05100	RECOVERY ROOM		0.202956	360,597	0	0	73,185	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.548622	542	0	0	297	52.00
53.00	05300	ANESTHESIOLOGY		0.133413	827,811	0	0	110,441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.151295	6,662,647	0	0	1,008,025	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0.106773	5,484,187	0	0	585,563	55.00
56.00	05600	RADIOISOTOPE		0.103848	1,951,239	0	0	202,632	56.00
57.00	05700	CT SCAN		0.033938	19,964,276	0	0	677,548	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.056679	4,403,276	0	0	249,573	58.00
60.00	06000	LABORATORY		0.149056	6,902,583	20,112	0	1,028,871	60.00
65.00	06500	RESPIRATORY THERAPY		0.112955	3,941,709	0	0	445,236	65.00
66.00	06600	PHYSICAL THERAPY		0.243839	113,280	0	0	27,622	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.218507	69,905	0	0	15,275	67.00
68.00	06800	SPEECH PATHOLOGY		0.305815	13,509	0	0	4,131	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.550018	804,086	140	0	442,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.583779	785,255	0	0	458,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.286969	6,245,331	0	54,304	1,792,216	73.00
74.00	07400	RENAL DIALYSIS		0.206746	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION		11.156911	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.616266	231,803	0	0	142,852	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.183880	781,245	0	0	143,655	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.213134	3,602,381	0	0	767,790	90.00
91.00	09100	EMERGENCY		0.328505	5,270,863	0	82	1,731,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.633765	1,006,355	0	0	637,793	92.00
200.00		Subtotal (see instructions)			76,935,859	20,252	54,386	12,144,738	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			76,935,859	20,252	54,386	12,144,738	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 8:29 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	2,998	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	77	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,584		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	27		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	3,075	15,611		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,075	15,611		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 8:29 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 8:29 am	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	35,711,509	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,808,993	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,564,850	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,462,939	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,400,220	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	13,521,367	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	4,390,623	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	69,881,791	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	15,722,077	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	51,099,983	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,598,246	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	26,848,218	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,530,356	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,778,429	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,350,763	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,852,590	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,088,581	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,335,904	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	36,237	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	527,852	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,290,886	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,723,365	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,702,831	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,235,612	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	367,464,222		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0058 Component CCN: 14-5951		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 8:29 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,636	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54,985	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	3,647	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	78,250	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	5,031	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	453,394	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	326,918	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	960,436	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	774,533	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	46,584	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	93,405	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	563,098	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	70,301	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	21	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			3,432,239	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058

Period:

Worksheet D

Component CCN: 14-5951

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 8:29 am

Title XVIII

Skilled Nursing
Facility

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	0.212945	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.202956	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.548622	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.133413	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151295	0	0	0	0 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.106773	0	0	0	0 55.00
56.00	05600 RADIOISOTOPE	0.103848	0	0	0	0 56.00
57.00	05700 CT SCAN	0.033938	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.056679	0	0	0	0 58.00
60.00	06000 LABORATORY	0.149056	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.112955	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.243839	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.218507	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.305815	0	0	0	0 68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.550018	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.583779	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.286969	0	0	5,989	0 73.00
74.00	07400 RENAL DIALYSIS	0.206746	0	0	0	0 74.00
76.00	03950 DIABETIC EDUCATION	11.156911	0	0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.616266	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.183880	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.213134	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.328505	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.633765	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	5,989	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	0	5,989	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058

Period:

Worksheet D

Component CCN: 14-5951

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/28/2022 8:29 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
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	1,719	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	1,719	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	1,719	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 8:29 am
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,702	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,702	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)		6,918	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)		3,416	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)		10,002,555	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)		10,002,555	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)		10,002,555	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,149.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,926,521	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)		3,926,521	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,948,768	1,401	2,104.76	522	1,098,685
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,694,754
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,719,960
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					475,107
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					454,029
52.00	Total Program excludable cost (sum of lines 50 and 51)					929,136
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,790,824
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,784
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,149.45
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,050,619

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058

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

Worksheet D-1

Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	987,960	10,002,555	0.098771	2,050,619	202,542	90.00
91.00 Nursing Program cost	0	10,002,555	0.000000	2,050,619	0	91.00
92.00 Allied health cost	0	10,002,555	0.000000	2,050,619	0	92.00
93.00 All other Medical Education	0	10,002,555	0.000000	2,050,619	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 8:29 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,140	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,140	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)		3,140	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,171	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,054,813	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,054,813	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,054,813	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 8:29 am
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				3,054,813	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				972.87	71.00
72.00 Program routine service cost (line 9 x line 71)				2,112,101	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				2,112,101	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				2,112,101	83.00
84.00 Program inpatient ancillary services (see instructions)				762,099	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				2,874,200	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: 14-0058 Component CCN: 14-5951		Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 8:29 am	
			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 8:29 am	
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		7,747,469		30.00
31.00	03100	INTENSIVE CARE UNIT		3,213,011		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212945	3,205,940	682,689	50.00
51.00	05100	RECOVERY ROOM	0.202956	328,687	66,709	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.548622	4,948	2,715	52.00
53.00	05300	ANESTHESIOLOGY	0.133413	420,192	56,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151356	1,537,647	232,732	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.106773	4,686	500	55.00
56.00	05600	RADIOISOTOPE	0.103848	92,990	9,657	56.00
57.00	05700	CT SCAN	0.033938	5,981,056	202,985	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.056679	280,647	15,907	58.00
60.00	06000	LABORATORY	0.149056	7,894,869	1,176,778	60.00
65.00	06500	RESPIRATORY THERAPY	0.113207	4,765,137	539,447	65.00
66.00	06600	PHYSICAL THERAPY	0.243839	686,917	167,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.218507	538,328	117,628	67.00
68.00	06800	SPEECH PATHOLOGY	0.305815	200,136	61,205	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.550018	898,373	494,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.583779	538,482	314,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.286969	4,503,581	1,292,388	73.00
74.00	07400	RENAL DIALYSIS	0.213631	710,456	151,775	74.00
76.00	03950	DIABETIC EDUCATION	11.156911	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.616266	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.183880	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.213319	917,973	195,821	90.00
91.00	09100	EMERGENCY	0.328505	2,211,364	726,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.633765	295,603	187,343	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		36,018,012	6,694,754	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)		36,018,012		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 8:29 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.212945	0	0	50.00
51.00	05100 RECOVERY ROOM	0.202956	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.548622	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.133413	1,636	218	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.151356	54,985	8,322	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.106773	0	0	55.00
56.00	05600 RADIOISOTOPE	0.103848	3,647	379	56.00
57.00	05700 CT SCAN	0.033938	78,250	2,656	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.056679	5,031	285	58.00
60.00	06000 LABORATORY	0.149056	453,394	67,581	60.00
65.00	06500 RESPIRATORY THERAPY	0.113207	326,918	37,009	65.00
66.00	06600 PHYSICAL THERAPY	0.243839	960,436	234,192	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.218507	774,533	169,241	67.00
68.00	06800 SPEECH PATHOLOGY	0.305815	46,584	14,246	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.550018	93,405	51,374	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.583779	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.286969	563,098	161,592	73.00
74.00	07400 RENAL DIALYSIS	0.213631	0	0	74.00
76.00	03950 DIABETIC EDUCATION	11.156911	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.616266	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.183880	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.213319	70,301	14,997	90.00
91.00	09100 EMERGENCY	0.328505	21	7	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.633765	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,432,239	762,099	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,432,239		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A
Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			9,042,235	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)			160,794	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)			101.11	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)			5.73	30.00
31.00	Percentage of Medicaid patient days (see instructions)			17.96	31.00
32.00	Sum of lines 30 and 31			23.69	32.00
33.00	Allowable disproportionate share percentage (see instructions)			8.76	33.00
34.00	Disproportionate share adjustment (see instructions)			198,025	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 8:29 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000029895		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	247,830	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	247,830	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		247,830		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)		9,648,884		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		11,810,344		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			11,810,344	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			688,950	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			203,435	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)			12,702,729	59.00
60.00	Primary payer payments			3,516	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			12,699,213	61.00
62.00	Deductibles billed to program beneficiaries			1,069,036	62.00
63.00	Coinsurance billed to program beneficiaries			20,139	63.00
64.00	Allowable bad debts (see instructions)			352,372	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			229,042	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			346,731	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			11,839,080	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)			0	70.93
70.94	HRR adjustment amount (see instructions)			20,463	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 8:29 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2021	979,647	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		137,028	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,702,162	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		12,764,401	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)		-62,239	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		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2022 8:29 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,042,235	0		9,042,235	9,042,235	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	160,794	0		160,794	160,794	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	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	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	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	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0876	0.0876	0.0876	0.0876		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	198,025	0	0	198,025	198,025	11.00
11.01	Uncompensated care payments	36.00	247,830	0	0	247,830	247,830	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	0	12.00
13.00	Subtotal (see instructions)	47.00	9,648,884	0	0	9,648,884	9,648,884	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	11,810,344	0	0	11,810,344	11,810,344	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,810,344	0	0	11,810,344	11,810,344	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	688,950	0	0	688,950	688,950	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2022 8:29 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	203,435	0	0	203,435	203,435	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	12,702,729	12,702,729	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	673,664	0	0	673,664	673,664	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	15,286	0	0	15,286	15,286	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	688,950	0	0	688,950	688,950	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	0.077121		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				979,647	979,647	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: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,042,235		9,042,235	9,042,235	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	160,794		160,794	160,794	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	0.0876	0.0876	0.0876		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	198,025	0	198,025	198,025	11.00
11.01	Uncompensated care payments	36.00	247,830	0	247,830	247,830	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,648,884	0	9,648,884	9,648,884	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	11,810,344	0	11,810,344	11,810,344	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,810,344	0	11,810,344	11,810,344	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	688,950	0	688,950	688,950	16.00
17.00	Special add-on payments for new technologies	54.00	203,435	0	203,435	203,435	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	12,702,729	12,702,729	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	673,664	0	673,664	673,664	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	15,286	0	15,286	15,286	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	688,950	0	688,950	688,950	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	979,647		979,647	979,647	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	20,463	0	20,463	20,463	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	137,028	137,028	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 8:29 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		18,686	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,144,738	2.00
3.00	OPPS payments		10,310,945	3.00
4.00	Outlier payment (see instructions)		6,854	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		18,686	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		74,638	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		74,638	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		74,638	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		55,952	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		18,686	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		10,317,799	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,056,013	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		8,280,472	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		8,280,472	30.00
31.00	Primary payer payments		680	31.00
32.00	Subtotal (line 30 minus line 31)		8,279,792	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		509,485	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		331,165	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		508,264	36.00
37.00	Subtotal (see instructions)		8,610,957	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,610,957	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		8,641,411	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-30,454	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems		PASSAVANT AREA HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0058	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 8:29 am	
		Component CCN: 14-5951			
		Title XVIII	Skilled Nursing Facility	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		1,719	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00	
3.00	OPPS payments			3.00	
4.00	Outlier payment (see instructions)			4.00	
4.01	Outlier reconciliation amount (see instructions)			4.01	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00	
6.00	Line 2 times line 5		0	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00	
8.00	Transitional corridor payment (see instructions)		0	8.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00	
10.00	Organ acquisitions		0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,719	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		5,989	12.00	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)		5,989	14.00	
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00	
18.00	Total customary charges (see instructions)		5,989	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,270	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00	
21.00	Lesser of cost or charges (see instructions)		1,719	21.00	
22.00	Interns and residents (see instructions)		0	22.00	
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,719	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00	
30.00	Subtotal (sum of lines 27 through 29)		1,719	30.00	
31.00	Primary payer payments		0	31.00	
32.00	Subtotal (line 30 minus line 31)		1,719	32.00	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00	
34.00	Allowable bad debts (see instructions)		0	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00	
37.00	Subtotal (see instructions)		1,719	37.00	
38.00	MSP-LCC reconciliation amount from PS&R			38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99	
40.00	Subtotal (see instructions)		1,719	40.00	
40.01	Sequestration adjustment (see instructions)		0	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs			40.03	
41.00	Interim payments		1,378	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		341	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00	
92.00	The rate used to calculate the Time Value of Money			92.00	
93.00	Time Value of Money (see instructions)			93.00	
94.00	Total (sum of lines 91 and 93)			94.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		12,871,500		8,666,526	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	06/23/2021	107,099	06/23/2021	25,115	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)		-107,099		-25,115	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)		12,764,401		8,641,411	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		62,239		30,454	6.02	
7.00	Total Medicare program liability (see instructions)		12,702,162		8,610,957	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0058
 Component CCN: 14-5951

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/28/2022 8:29 am

		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,131,035		1,378		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0		3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,131,035		1,378		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		341		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,131,035		1,719		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/28/2022 8:29 am

		Title XVIII	Hospital	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 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: 14-0058 Component CCN: 14-5951	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2022 8:29 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)			1,205,665 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,205,665 4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			74,630 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			1,131,035 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			1,131,035 15.00
15.01	Sequestration adjustment (see instructions)			0 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			0 15.75
16.00	Interim payments			1,131,035 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

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

Provider CCN: 14-0058

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

Worksheet G

Date/Time Prepared:
2/28/2022 8:29 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	2,122,784	0	0	0	1.00
2.00 Temporary investments	19,066,016	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	16,712,632	0	0	0	4.00
5.00 Other receivable	-4,932,135	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-3,285,428	0	0	0	6.00
7.00 Inventory	1,829,801	0	0	0	7.00
8.00 Prepaid expenses	1,164,090	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	32,677,760	0	0	0	11.00
FIXED ASSETS					
12.00 Land	735,200	0	0	0	12.00
13.00 Land improvements	1,281,184	0	0	0	13.00
14.00 Accumulated depreciation	-533,839	0	0	0	14.00
15.00 Buildings	14,907,174	0	0	0	15.00
16.00 Accumulated depreciation	-3,153,131	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	22,664,161	0	0	0	19.00
20.00 Accumulated depreciation	-8,048,158	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	22,666,381	0	0	0	23.00
24.00 Accumulated depreciation	-13,865,631	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	753,492	0	0	0	27.00
28.00 Accumulated depreciation	-902,519	0	0	0	28.00
29.00 Minor equipment-nondepreciable	20,365,919	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	56,870,233	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	109,788,264	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	25,246,867	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	135,035,131	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	224,583,124	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,567,183	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,239,043	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,368,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	9,578,629	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	20,752,855	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	14,847,459	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	2,514,113	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	17,361,572	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	38,114,427	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	186,468,697	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	186,468,697	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	224,583,124	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0058

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

Worksheet G-1

Date/Time Prepared:
2/28/2022 8:29 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		152,081,492		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		34,492,957				2.00
3.00	Total (sum of line 1 and line 2)		186,574,449		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		186,574,449		0		11.00
12.00	CHANGE IN PY FUND BALANCE	105,752		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		105,752		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		186,468,697		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN PY FUND BALANCE		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 8:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,597,468		17,597,468	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,759,336		4,759,336	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)	22,356,804		22,356,804	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,178,323		8,178,323	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)	8,178,323		8,178,323	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,535,127		30,535,127	17.00
18.00	Ancillary services	65,684,290	267,172,622	332,856,912	18.00
19.00	Outpatient services	6,942,708	33,059,061	40,001,769	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	94,240	94,240	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	4,397	4,397	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	103,162,125	300,330,320	403,492,445	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		92,025,407		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)		92,025,407		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0058

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

Worksheet G-3

Date/Time Prepared:
2/28/2022 8:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	403,492,445	1.00
2.00	Less contractual allowances and discounts on patients' accounts	301,422,249	2.00
3.00	Net patient revenues (line 1 minus line 2)	102,070,196	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	92,025,407	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,044,789	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,209,292	6.00
7.00	Income from investments	805,067	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	469,362	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	16,280	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	8,574	21.00
22.00	Rental of hospital space	453,322	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	515,187	24.00
24.01	340B INCOME	40,900	24.01
24.02	INTEREST PENALTY INCOME	31,941	24.02
24.03	REALIZED GAIN ON INVESTMENTS	3,617,178	24.03
24.04	UNREALIZED GAIN ON INVESTMENTS	13,533,320	24.04
24.05	EQUITY INCOME OF AFFILIATE	794,458	24.05
24.06	PROVISION FOR INCOME TAXES	2,329	24.06
24.50	COVID-19 PHE Funding	3,535,020	24.50
25.00	Total other income (sum of lines 6-24)	25,032,230	25.00
26.00	Total (line 5 plus line 25)	35,077,019	26.00
27.00	RETIREE BENEFIT ADJUSTMENT	221,772	27.00
27.01	CHANGE IN FMV OF INTEREST RATE SWAP	195,936	27.01
27.02	LOSS ON DISPOSAL OF FIXED ASSETS	166,354	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	584,062	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	34,492,957	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0058

Period:
From 10/01/2020
To 09/30/2021Worksheet L
Parts I-III
Date/Time Prepared:
2/28/2022 8:29 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	673,664	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	15,286	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)	23.46	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)	688,950	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