

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: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 7/27/2022 12:21 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TOUCHETTE REGIONAL HOSPITAL (14-0077) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	John Jeffries	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	John Jeffries		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	417,425	-16,108	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
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	417,425	-16,108	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: 14-0077		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/27/2022 12:21 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5900 BOND STREET			PO Box:				1.00		
2.00	City: CENTREVILLE			State: IL		Zip Code: 62207		County: ST. CLAIR 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		TOUCHETTE REGIONAL HOSPITAL	140077	41180	1	07/01/1966	N	P N	3.00
4.00	Subprovider - IPF		TOUCHETTE REGIONAL HOSPITAL	14S077	41180	1	01/01/2021	N	P N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA		SOUTHERN ILLINOIS HOME CARE	147315	41180		01/01/1996	N	P N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2021		12/31/2021		20.00
21.00	Type of Control (see instructions)					2				21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N		N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				3	N				23.00

Worksheet S-2
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

MCRIF32 - 17.7.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0077		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/27/2022 12:21 pm			
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
			1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00		
			Y/N	IME	Direct GME	IME	Direct GME		
			1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
							1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

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

MCRIF32 - 17.7.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 7/27/2022 12:21 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,444,063	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101						
142.00	Street: 2041 GOOSE LAKE ROAD	PO Box:								
143.00	City: SAUGET	State:		Zip Code:		62206				
								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	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	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)								9.99	169.00
								Beginning	Ending	
								1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
								1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/27/2022 12:21 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/17/2022	Y 03/17/2022
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: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/27/2022 12:21 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/27/2022 12:21 pm
		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: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	127	46,355	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)		127	46,355	0.00	0	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)		127	46,355	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		137			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: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	936	217	7,001			1.00
2.00	HMO and other (see instructions)	0	3,872				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)	936	217	7,001			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)	936	217	7,001	0.00	360.30	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	764	0.00	6.36	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	606	0	5,379	0.00	7.53	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	374.19	27.00
28.00	Observation Bed Days		0	1,130			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	214	68	2,043	1.00
2.00 HMO and other (see instructions)			0	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	214	68	2,043	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	119	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/27/2022 12:21 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	24,444,978	0	24,444,978	778,313.23	31.41
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		287,921	0	287,921	3,658.63	78.70
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,914,281	441,966	3,356,247	93,183.91	36.02
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		8,812,601	0	8,812,601	80,618.23	109.31
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		59,163	0	59,163	431.00	137.27
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,596,795	0	5,596,795		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,520,496	0	2,520,496		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		31,753	0	31,753		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/27/2022 12:21 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	536,540	0	536,540	13,757.13	39.00	26.00
27.00	Administrative & General	5.00	5,457,752	0	5,457,752	148,798.11	36.68	27.00
28.00	Administrative & General under contract (see inst.)		934,137	0	934,137	11,137.07	83.88	28.00
29.00	Maintenance & Repairs	6.00	704,620	0	704,620	23,966.91	29.40	29.00
30.00	Operation of Plant	7.00	1,300,856	0	1,300,856	61,667.30	21.09	30.00
31.00	Laundry & Linen Service	8.00	23,833	0	23,833	1,615.38	14.75	31.00
32.00	Housekeeping	9.00	659,871	0	659,871	43,179.91	15.28	32.00
33.00	Housekeeping under contract (see instructions)		107,458	0	107,458	2,080.00	51.66	33.00
34.00	Dietary	10.00	497,997	-315,848	182,149	11,564.72	15.75	34.00
35.00	Dietary under contract (see instructions)		157,670	0	157,670	4,160.00	37.90	35.00
36.00	Cafeteria	11.00	0	315,848	315,848	20,653.10	15.29	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	648,298	0	648,298	13,074.84	49.58	38.00
39.00	Central Services and Supply	14.00	56,382	0	56,382	3,128.94	18.02	39.00
40.00	Pharmacy	15.00	500,871	-500,871	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	481,272	0	481,272	24,220.30	19.87	41.00
42.00	Social Service	17.00	103,021	0	103,021	3,577.55	28.80	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
7/27/2022 12:21 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	25,356,322	0	25,356,322	792,031.67	32.01	1.00
2.00	Excluded area salaries (see instructions)	2,914,281	441,966	3,356,247	93,183.91	36.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,442,041	-441,966	22,000,075	698,847.76	31.48	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,871,764	0	8,871,764	81,049.23	109.46	4.00
5.00	Subtotal wage-related costs (see inst.)	5,596,795	0	5,596,795	0.00	25.44	5.00
6.00	Total (sum of lines 3 thru 5)	36,910,600	-441,966	36,468,634	779,896.99	46.76	6.00
7.00	Total overhead cost (see instructions)	12,170,578	-500,871	11,669,707	386,581.26	30.19	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 7/27/2022 12:21 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		543,962	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		3,409,971	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)		67,200	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)		84,177	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		400,305	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,786,528	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		46,746	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		23,627	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,362,516	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: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	9,185,275	6,362,516	1.00
2.00	Hospital	8,812,601	6,089,411	2.00
3.00	SUBPROVIDER - IPF	0	115,034	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	372,674	158,071	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		TOUCHETTE REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0077 Component CCN: 14-7315		Period: From 01/01/2021 To 12/31/2021	Worksheet S-4 Date/Time Prepared: 7/27/2022 12:21 pm		
				Home Health Agency I	PPS		
				1.00			
0.00	County	ST. CLAIR				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0 1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	40.00	114.00	25.00	179.00 2.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00 3.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00 4.00	
5.00	Other Administrative Personnel			2.89	0.00	2.89 5.00	
6.00	Direct Nursing Service			2.47	0.00	2.47 6.00	
7.00	Nursing Supervisor			2.10	0.00	2.10 7.00	
8.00	Physical Therapy Service			0.00	0.00	0.00 8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00 10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00	
12.00	Speech Pathology Service			0.00	0.00	0.00 12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00	
14.00	Medical Social Service			0.07	0.00	0.07 14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00	
16.00	Home Health Aide			0.00	0.00	0.00 16.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00 17.00	
18.00	Other (specify)			0.00	0.00	0.00 18.00	
					CBSA Data		
					1.00		
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					41180	20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	108	51	12	0	171 21.00	
22.00	Skilled Nursing Visit Charges	22,050	10,200	2,500	0	34,750 22.00	
23.00	Physical Therapy Visits	192	79	4	0	275 23.00	
24.00	Physical Therapy Visit Charges	47,500	19,650	950	0	68,100 24.00	
25.00	Occupational Therapy Visits	82	44	3	0	129 25.00	
26.00	Occupational Therapy Visit Charges	20,300	10,900	700	0	31,900 26.00	
27.00	Speech Pathology Visits	5	22	0	0	27 27.00	
28.00	Speech Pathology Visit Charges	1,250	5,500	0	0	6,750 28.00	
29.00	Medical Social Service Visits	2	2	0	0	4 29.00	
30.00	Medical Social Service Visit Charges	500	500	0	0	1,000 30.00	
31.00	Home Health Aide Visits	0	0	0	0	0 31.00	
32.00	Home Health Aide Visit Charges	0	0	0	0	0 32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	389	198	19	0	606 33.00	
34.00	Other Charges	0	0	0	0	0 34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	91,600	46,750	4,150	0	142,500 35.00	
36.00	Total Number of Episodes (standard/non outlier)	39		10	0	49 36.00	
37.00	Total Number of Outlier Episodes		10		0	10 37.00	
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0 38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 7/27/2022 12:21 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.973350	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			11,336,739	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			29,657,176	5.00
6.00	Medicaid charges			37,873,536	6.00
7.00	Medicaid cost (line 1 times line 6)			36,864,206	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			21,924	9.00
10.00	Stand-alone CHIP charges			83,165	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			80,949	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			59,025	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)			59,025	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,144,321	287,087	2,431,408	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,087,175	287,087	2,374,262	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,087,175	287,087	2,374,262	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)			1,888,958	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			78,205	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			120,316	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,768,642	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,763,619	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,137,881	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,196,906	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0077

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

Worksheet A

Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,296,803	1,296,803	141,419	1,438,222	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		713,780	713,780	68,848	782,628	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	536,540	4,926,115	5,462,655	-34,209	5,428,446	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,457,752	9,967,644	15,425,396	208,940	15,634,336	5.00
6.00	00600	MAINTENANCE & REPAIRS	704,620	431,369	1,135,989	0	1,135,989	6.00
7.00	00700	OPERATION OF PLANT	1,300,856	817,772	2,118,628	0	2,118,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,833	84,216	108,049	0	108,049	8.00
9.00	00900	HOUSEKEEPING	659,871	425,709	1,085,580	0	1,085,580	9.00
10.00	01000	DIETARY	497,997	682,990	1,180,987	-757,067	423,920	10.00
11.00	01100	CAFETERIA	0	0	0	757,067	757,067	11.00
13.00	01300	NURSING ADMINISTRATION	648,298	360,214	1,008,512	0	1,008,512	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,382	18,269	74,651	0	74,651	14.00
15.00	01500	PHARMACY	500,871	614,393	1,115,264	-500,871	614,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	481,272	155,255	636,527	0	636,527	16.00
17.00	01700	SOCIAL SERVICE	103,021	8,549	111,570	0	111,570	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,780,140	8,738,193	13,518,333	-1,168,258	12,350,075	30.00
40.00	04000	SUBPROVIDER - IPF	0	36,744	36,744	1,181,370	1,218,114	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,127,580	549,042	1,676,622	0	1,676,622	50.00
53.00	05300	ANESTHESIOLOGY	0	827,382	827,382	0	827,382	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,311,540	594,991	1,906,531	0	1,906,531	54.00
60.00	06000	LABORATORY	776,072	2,410,398	3,186,470	0	3,186,470	60.00
65.00	06500	RESPIRATORY THERAPY	675,286	388,250	1,063,536	0	1,063,536	65.00
66.00	06600	PHYSICAL THERAPY	0	446,459	446,459	0	446,459	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	147,508	147,508	0	147,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,238	203,238	0	203,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	375,042	375,042	500,871	875,913	73.00
74.00	07400	RENAL DIALYSIS	0	13,471	13,471	0	13,471	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	409,382	371,814	781,196	0	781,196	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,479,384	5,271,048	6,750,432	0	6,750,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	607,312	562,514	1,169,826	0	1,169,826	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		419,207	419,207	-419,207	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,138,009	41,858,379	63,996,388	-21,097	63,975,291	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	1,977,891	4,660,052	6,637,943	21,097	6,659,040	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	73,768	5,158	78,926	0	78,926	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	255,310	6,336	261,646	0	261,646	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	24,444,978	46,529,925	70,974,903	0	70,974,903	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0077

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

Worksheet A

Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-22,268	1,415,954	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,210	778,418	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,428,446	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,803,207	12,831,129	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,135,989	6.00
7.00	00700	OPERATION OF PLANT	0	2,118,628	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,049	8.00
9.00	00900	HOUSEKEEPING	0	1,085,580	9.00
10.00	01000	DIETARY	0	423,920	10.00
11.00	01100	CAFETERIA	-237,731	519,336	11.00
13.00	01300	NURSING ADMINISTRATION	-108	1,008,404	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	74,651	14.00
15.00	01500	PHARMACY	0	614,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,182	616,345	16.00
17.00	01700	SOCIAL SERVICE	0	111,570	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,244,034	11,106,041	30.00
40.00	04000	SUBPROVIDER - IPF	-7,945	1,210,169	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,676,622	50.00
53.00	05300	ANESTHESIOLOGY	-809,805	17,577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-240	1,906,291	54.00
60.00	06000	LABORATORY	0	3,186,470	60.00
65.00	06500	RESPIRATORY THERAPY	-40,139	1,023,397	65.00
66.00	06600	PHYSICAL THERAPY	0	446,459	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	147,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	203,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	875,913	73.00
74.00	07400	RENAL DIALYSIS	0	13,471	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-74,394	706,802	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-3,578,458	3,171,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,169,826	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,842,721	55,132,570	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,659,040	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	78,926	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	261,646	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,842,721	62,132,182	200.00

RECLASSIFICATIONS

Provider CCN: 14-0077

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

Worksheet A-6

Date/Time Prepared:
7/27/2022 12:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - CAFETERIA COSTS					
	CAFETERIA	11.00	315,848	441,219		1.00
	0		315,848	441,219		
1.00	B - ER & HOSPITALIST PHYSICIAN BENEFITS					
	ADULTS & PEDIATRICS	30.00	0	13,112		1.00
	0		0	13,112		
1.00	C - CLINIC PHYSICIAN BENEFITS					
	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,097		1.00
	0		0	21,097		
1.00	D - INTEREST EXPENSE					
	CAP REL COSTS-MVBLE EQUIP	2.00	0	664		1.00
	ADMINISTRATIVE & GENERAL	5.00	0	418,543		2.00
	0		0	419,207		
1.00	E - PROPERTY INSURANCE					
	OTHER CAP REL COSTS	3.00	0	209,603		1.00
	0	0.00	0	0		2.00
	0		0	209,603		
1.00	G - PHARMACY					
	DRUGS CHARGED TO PATIENTS	73.00	500,871	0		1.00
	0		500,871	0		
1.00	H - SUBPROVIDER - IPF					
	SUBPROVIDER - IPF	40.00	441,966	739,404		1.00
	TOTALS		441,966	739,404		
500.00	Grand Total: Increases		1,258,685	1,843,642		500.00

RECLASSIFICATIONS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet A-6
Date/Time Prepared:
7/27/2022 12:21 pm

		Decreases				Wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA COSTS							
1.00	DIETARY		10.00	315,848	441,219	0	1.00
				315,848	441,219		
B - ER & HOSPITALIST PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	13,112	0	1.00
				0	13,112		
C - CLINIC PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	21,097	0	1.00
				0	21,097		
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE		113.00	0	419,207	11	1.00
2.00			0.00	0	0	0	2.00
				0	419,207		
E - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL		5.00	0	209,603	12	1.00
2.00			0.00	0	0	12	2.00
				0	209,603		
G - PHARMACY							
1.00	PHARMACY		15.00	500,871	0	0	1.00
				500,871	0		
H - SUBPROVIDER - IPF							
1.00	ADULTS & PEDIATRICS		30.00	441,966	739,404	0	1.00
	TOTALS			441,966	739,404		
500.00	Grand Total: Decreases			1,258,685	1,843,642		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,222,647	0	0	0	30,000	1.00	
2.00	Land Improvements	307,583	0	0	0	0	2.00	
3.00	Buildings and Fixtures	30,956,449	230,226	0	230,226	133,640	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	788,179	59,000	0	59,000	0	5.00	
6.00	Movable Equipment	15,046,349	1,544,084	0	1,544,084	4,486	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	49,321,207	1,833,310	0	1,833,310	168,126	8.00	
9.00	Reconciling Items	-595,901	0	0	0	-47,319	9.00	
10.00	Total (line 8 minus line 9)	49,917,108	1,833,310	0	1,833,310	215,445	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,192,647	0					1.00
2.00	Land Improvements	307,583	0					2.00
3.00	Buildings and Fixtures	31,053,035	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	847,179	0					5.00
6.00	Movable Equipment	16,585,947	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	50,986,391	0					8.00
9.00	Reconciling Items	-548,582	0					9.00
10.00	Total (line 8 minus line 9)	51,534,973	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,296,803	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	713,780	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,010,583	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	1,296,803				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	713,780				2.00
3.00	Total (sum of lines 1-2)	0	2,010,583				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	34,400,444	0	34,400,444	0.674699	141,419	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,585,947	0	16,585,947	0.325301	68,184	2.00
3.00	Total (sum of lines 1-2)	50,986,391	0	50,986,391	1.000000	209,603	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	141,419	1,274,535	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	68,184	709,574	0	2.00
3.00	Total (sum of lines 1-2)	0	0	209,603	1,984,109	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	141,419	0	0	1,415,954	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	660	68,184	0	0	778,418	2.00
3.00	Total (sum of lines 1-2)	660	209,603	0	0	2,194,372	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0077

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

Worksheet A-8

Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-4	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-2,721	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,239	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-10,879	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-28,536	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,743,028			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-240	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-249,574			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-237,731	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-108	NURSING ADMINISTRATION	13.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20,182	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-146,930	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0077

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

Worksheet A-8

Date/Time Prepared:
7/27/2022 12:21 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 INSURANCE PROCEEDS	B	-22,268	CAP REL COSTS-BLDG & FIXT	1.00		9 33.01
33.02 LOBBYING COSTS	A	-14,389	ADMINISTRATIVE & GENERAL	5.00		0 33.02
34.00 MARKETING COSTS - OTHER EXPENSES	A	-86,915	ADMINISTRATIVE & GENERAL	5.00		0 34.00
35.00 NON-ALLOWABLE ADVERTISING	A	-320	ADMINISTRATIVE & GENERAL	5.00		0 35.00
35.01 NON-ALLOWABLE ADVERTISING	A	-4,497	ADULTS & PEDIATRICS	30.00		0 35.01
35.02 NON-ALLOWABLE ADVERTISING	A	-4,625	SUBPROVIDER - IPF	40.00		0 35.02
36.00 NON-ALLOWABLE ADVERTISING	A	-2,625	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00		0 36.00
37.00 PROVIDER TAX	A	-2,261,704	ADMINISTRATIVE & GENERAL	5.00		0 37.00
38.00 AMORTIZE EQUIPMENT INSURANCE PROCEED	A	-4,206	CAP REL COSTS-MVBLE EQUIP	2.00		9 38.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,842,721				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: 14-0077

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

Worksheet A-8-1

Date/Time Prepared:
7/27/2022 12:21 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	SIHF SERVICES	0	249,574	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	249,574	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

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

Provider CCN: 14-0077

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

Worksheet A-8-1

Date/Time Prepared:
7/27/2022 12:21 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-249,574	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-249,574			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	NOT FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0077

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

Worksheet A-8-2

Date/Time Prepared:
7/27/2022 12:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,248,100	1,230,245	17,855	211,500	119	1.00
2.00	30.00	ADULTS & PEDIATRICS	6,000	0	6,000	237,100	48	2.00
3.00	30.00	ADULTS & PEDIATRICS	9,808	0	9,808	181,300	78	3.00
4.00	40.00	SUBPROVIDER - IPF	11,077	0	11,077	181,300	89	4.00
5.00	53.00	ANESTHESIOLOGY	809,805	809,805	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	49,290	35,790	13,500	211,500	90	6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	80,137	68,137	12,000	181,300	96	7.00
8.00	91.00	EMERGENCY	3,578,458	3,578,458	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			5,792,675	5,722,435	70,240		520	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	12,100	605	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	5,472	274	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	6,799	340	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	7,757	388	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	9,151	458	0	0	0	6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,368	418	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			49,647	2,483	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	12,100	5,755	1,236,000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	5,472	528	528		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	6,799	3,009	3,009		3.00
4.00	40.00	SUBPROVIDER - IPF	0	7,757	3,320	3,320		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	809,805		5.00
6.00	65.00	RESPIRATORY THERAPY	0	9,151	4,349	40,139		6.00
7.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8,368	3,632	71,769		7.00
8.00	91.00	EMERGENCY	0	0	0	3,578,458		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	49,647	20,593	5,743,028		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,415,954	1,415,954			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	778,418		778,418		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,428,446	9,035	4,967	5,442,448	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,831,129	80,047	44,005	1,311,694	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,135,989	67,440	37,075	169,344	6.00
7.00	00700	OPERATION OF PLANT	2,118,628	219,439	120,636	312,640	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,049	10,840	5,960	5,728	8.00
9.00	00900	HOUSEKEEPING	1,085,580	21,060	11,578	158,589	9.00
10.00	01000	DIETARY	423,920	60,035	33,004	43,777	10.00
11.00	01100	CAFETERIA	519,336	21,759	11,962	75,909	11.00
13.00	01300	NURSING ADMINISTRATION	1,008,404	35,443	19,484	155,808	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,651	17,847	9,812	13,551	14.00
15.00	01500	PHARMACY	614,393	14,946	8,216	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	616,345	26,009	14,299	115,666	16.00
17.00	01700	SOCIAL SERVICE	111,570	4,610	2,534	24,759	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,106,041	317,420	174,500	973,795	30.00
40.00	04000	SUBPROVIDER - IPF	1,210,169	73,117	40,196	106,219	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,676,622	138,664	76,231	270,996	50.00
53.00	05300	ANESTHESIOLOGY	17,577	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,906,291	36,869	20,269	315,208	54.00
60.00	06000	LABORATORY	3,186,470	37,898	20,834	186,516	60.00
65.00	06500	RESPIRATORY THERAPY	1,023,397	34,870	19,170	162,294	65.00
66.00	06600	PHYSICAL THERAPY	446,459	30,027	16,507	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,508	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	203,238	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	875,913	0	0	120,376	73.00
74.00	07400	RENAL DIALYSIS	13,471	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	706,802	49,340	27,125	98,388	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,171,974	106,347	58,464	355,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,169,826	0	0	145,958	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,132,570	1,413,062	776,828	5,122,761	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,659,040	0	0	240,598	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	78,926	0	0	17,729	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	261,646	2,892	1,590	61,360	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	62,132,182	1,415,954	778,418	5,442,448	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,266,875					5.00
6.00	00600	MAINTENANCE & REPAIRS	420,224	1,830,072				6.00
7.00	00700	OPERATION OF PLANT	826,035	318,865	3,916,243			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,920	15,752	40,821	226,070		8.00
9.00	00900	HOUSEKEEPING	380,569	30,602	79,304	0	1,767,282	9.00
10.00	01000	DIETARY	167,135	87,236	226,070	0	6,544	10.00
11.00	01100	CAFETERIA	187,471	31,617	81,935	0	26,177	11.00
13.00	01300	NURSING ADMINISTRATION	363,380	51,501	133,464	0	26,177	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,534	25,934	67,207	0	19,632	14.00
15.00	01500	PHARMACY	190,032	21,717	56,280	0	16,360	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	230,200	37,794	97,942	0	16,360	16.00
17.00	01700	SOCIAL SERVICE	42,764	6,699	17,359	0	9,816	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,747,172	461,243	1,195,288	103,155	620,241	30.00
40.00	04000	SUBPROVIDER - IPF	426,141	106,246	275,333	7,620	40,875	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	644,565	201,492	522,161	6,783	278,178	50.00
53.00	05300	ANESTHESIOLOGY	5,239	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,177	53,574	138,836	33,910	101,434	54.00
60.00	06000	LABORATORY	1,022,868	55,069	142,710	0	49,133	60.00
65.00	06500	RESPIRATORY THERAPY	369,518	50,669	131,308	2,261	49,133	65.00
66.00	06600	PHYSICAL THERAPY	146,943	43,632	113,072	11,303	55,625	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,967	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	296,957	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,015	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	262,789	71,696	185,797	0	65,441	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,100,547	154,532	400,465	61,038	327,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	392,187	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,083,927	1,825,870	3,905,352	226,070	1,708,385	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	2,056,527	0	0	0	49,081	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	28,809	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	97,612	4,202	10,891	0	9,816	194.01
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)	14,266,875	1,830,072	3,916,243	226,070	1,767,282	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,047,721					10.00
11.00	01100	CAFETERIA	0	956,166				11.00
13.00	01300	NURSING ADMINISTRATION	0	28,600	1,822,261			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,835	23,571	293,574		14.00
15.00	01500	PHARMACY	0	25,796	0	199	947,939	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,924	0	72	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,816	0	9	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	951,699	274,081	916,926	38,931	10,433	30.00
40.00	04000	SUBPROVIDER - IPF	96,022	28,915	99,699	22	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	64,700	222,946	33,710	13,720	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,877	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,748	0	6,364	41,776	54.00
60.00	06000	LABORATORY	0	70,203	0	63,348	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	43,040	0	5,530	4,182	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,246	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	35,975	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	49,566	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	800,180	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	56	37	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	31,158	107,254	345	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	96,875	333,846	40,056	29,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	118,019	3,511	64	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,047,721	815,691	1,822,261	282,817	899,444	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	98,557	0	10,446	48,495	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	7,535	0	22	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	34,383	0	289	0	194.01
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)	1,047,721	956,166	1,822,261	293,574	947,939	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,207,611					16.00
17.00	01700	SOCIAL SERVICE	0	227,936				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	966,438	124,356	21,981,719	0	21,981,719	30.00
40.00	04000	SUBPROVIDER - IPF	95,731	13,521	2,619,826	0	2,619,826	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	30,236	4,181,004	0	4,181,004	50.00
53.00	05300	ANESTHESIOLOGY	0	0	26,693	0	26,693	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,418,456	0	3,418,456	54.00
60.00	06000	LABORATORY	0	0	4,835,049	0	4,835,049	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,895,372	0	1,895,372	65.00
66.00	06600	PHYSICAL THERAPY	0	0	864,814	0	864,814	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	227,450	0	227,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	313,382	0	313,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,093,426	0	2,093,426	73.00
74.00	07400	RENAL DIALYSIS	0	0	17,579	0	17,579	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	14,546	1,620,681	0	1,620,681	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	145,442	45,277	6,426,720	0	6,426,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	1,829,565	0	1,829,565	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,207,611	227,936	52,351,736	0	52,351,736	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	9,162,744	0	9,162,744	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	133,021	0	133,021	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	484,681	0	484,681	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,207,611	227,936	62,132,182	0	62,132,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,035	4,967	14,002	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	128,450	80,047	44,005	252,502	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	67,440	37,075	104,515	6.00
7.00	00700	OPERATION OF PLANT	375	219,439	120,636	340,450	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,840	5,960	16,800	8.00
9.00	00900	HOUSEKEEPING	0	21,060	11,578	32,638	9.00
10.00	01000	DIETARY	0	60,035	33,004	93,039	10.00
11.00	01100	CAFETERIA	0	21,759	11,962	33,721	11.00
13.00	01300	NURSING ADMINISTRATION	0	35,443	19,484	54,927	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	765	17,847	9,812	28,424	14.00
15.00	01500	PHARMACY	89,175	14,946	8,216	112,337	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,009	14,299	40,308	16.00
17.00	01700	SOCIAL SERVICE	0	4,610	2,534	7,144	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	420	317,420	174,500	492,340	30.00
40.00	04000	SUBPROVIDER - IPF	0	73,117	40,196	113,313	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	94,341	138,664	76,231	309,236	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,019	36,869	20,269	161,157	54.00
60.00	06000	LABORATORY	0	37,898	20,834	58,732	60.00
65.00	06500	RESPIRATORY THERAPY	5,803	34,870	19,170	59,843	65.00
66.00	06600	PHYSICAL THERAPY	0	30,027	16,507	46,534	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	310	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	39,308	49,340	27,125	115,773	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	106,347	58,464	164,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	15,996	0	0	15,996	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	478,652	1,413,062	776,828	2,668,542	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	216,610	0	0	216,610	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	46	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	2,892	1,590	4,482	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	695,262	1,415,954	778,418	2,889,634	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	255,880					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,537	112,487				6.00
7.00	00700	OPERATION OF PLANT	14,816	19,599	375,669			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	698	968	3,916	22,397		8.00
9.00	00900	HOUSEKEEPING	6,826	1,881	7,607	0	49,360	9.00
10.00	01000	DIETARY	2,998	5,362	21,686	0	183	10.00
11.00	01100	CAFETERIA	3,362	1,943	7,860	0	731	11.00
13.00	01300	NURSING ADMINISTRATION	6,518	3,166	12,803	0	731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	619	1,594	6,447	0	548	14.00
15.00	01500	PHARMACY	3,408	1,335	5,399	0	457	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,129	2,323	9,395	0	457	16.00
17.00	01700	SOCIAL SERVICE	767	412	1,665	0	274	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,199	28,351	114,657	10,219	17,324	30.00
40.00	04000	SUBPROVIDER - IPF	7,643	6,531	26,412	755	1,142	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,561	12,385	50,089	672	7,769	50.00
53.00	05300	ANESTHESIOLOGY	94	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,182	3,293	13,318	3,360	2,833	54.00
60.00	06000	LABORATORY	18,346	3,385	13,690	0	1,372	60.00
65.00	06500	RESPIRATORY THERAPY	6,628	3,114	12,596	224	1,372	65.00
66.00	06600	PHYSICAL THERAPY	2,636	2,682	10,846	1,120	1,554	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	789	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,087	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,326	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	72	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,713	4,407	17,823	0	1,828	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,739	9,498	38,415	6,047	9,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	7,034	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	216,727	112,229	374,624	22,397	47,715	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	36,885	0	0	0	1,371	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	517	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	1,751	258	1,045	0	274	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	255,880	112,487	375,669	22,397	49,360	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	123,381					10.00
11.00	01100	CAFETERIA	0	47,812				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,430	79,976			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	342	1,034	39,043		14.00
15.00	01500	PHARMACY	0	1,290	0	26	124,252	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,646	0	10	0	16.00
17.00	01700	SOCIAL SERVICE	0	391	0	1	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	112,073	13,706	40,242	5,178	1,368	30.00
40.00	04000	SUBPROVIDER - IPF	11,308	1,446	4,376	3	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,235	9,785	4,483	1,798	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	516	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,238	0	846	5,476	54.00
60.00	06000	LABORATORY	0	3,510	0	8,426	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,152	0	735	548	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	166	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,784	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,592	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	104,884	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7	5	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,558	4,707	46	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,844	14,652	5,327	3,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	5,180	467	8	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	123,381	40,788	79,976	37,613	117,895	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	4,928	0	1,389	6,357	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	377	0	3	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	1,719	0	38	0	194.01
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)	123,381	47,812	79,976	39,043	124,252	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,565					16.00
17.00	01700	SOCIAL SERVICE	0	10,718				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,669	5,847	958,677	0	958,677	30.00
40.00	04000	SUBPROVIDER - IPF	4,722	636	178,560	0	178,560	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,422	413,132	0	413,132	50.00
53.00	05300	ANESTHESIOLOGY	0	0	610	0	610	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	207,514	0	207,514	54.00
60.00	06000	LABORATORY	0	0	107,941	0	107,941	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	87,629	0	87,629	65.00
66.00	06600	PHYSICAL THERAPY	0	0	65,538	0	65,538	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,573	0	5,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,679	0	7,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	110,520	0	110,520	73.00
74.00	07400	RENAL DIALYSIS	0	0	84	0	84	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	684	151,792	0	151,792	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,174	2,129	286,498	0	286,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	29,060	0	29,060	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,565	10,718	2,610,807	0	2,610,807	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	268,159	0	268,159	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	943	0	943	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	0	9,725	0	9,725	194.01
200.00		Cross Foot Adjustments			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)	59,565	10,718	2,889,634	0	2,889,634	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	145,900				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		145,900			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	931	931	22,645,312		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,248	8,248	5,457,752	-14,266,875	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,949	6,949	704,620	0	6.00
7.00	00700	OPERATION OF PLANT	22,611	22,611	1,300,856	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	23,833	0	8.00
9.00	00900	HOUSEKEEPING	2,170	2,170	659,871	0	9.00
10.00	01000	DIETARY	6,186	6,186	182,149	0	10.00
11.00	01100	CAFETERIA	2,242	2,242	315,848	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,652	3,652	648,298	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,839	1,839	56,382	0	14.00
15.00	01500	PHARMACY	1,540	1,540	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,680	2,680	481,272	0	16.00
17.00	01700	SOCIAL SERVICE	475	475	103,021	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,707	32,707	4,051,839	0	30.00
40.00	04000	SUBPROVIDER - IPF	7,534	7,534	441,966	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,288	14,288	1,127,580	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,799	3,799	1,311,540	0	54.00
60.00	06000	LABORATORY	3,905	3,905	776,072	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,593	3,593	675,286	0	65.00
66.00	06600	PHYSICAL THERAPY	3,094	3,094	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	500,871	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,084	5,084	409,382	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,958	10,958	1,479,384	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				3,692,331	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	607,312	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,602	145,602	21,315,134	-14,266,875	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,001,100	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	73,768	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	298	298	255,310	0	194.01
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)	1,415,954	778,418	5,442,448	14,266,875	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.704962	5.335284	0.240334	0.298063	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,002	255,880	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000618	0.005346	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: 14-0077

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	129,772				6.00
7.00	00700	OPERATION OF PLANT	22,611	107,161			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	161,087		8.00
9.00	00900	HOUSEKEEPING	2,170	2,170	0	34,027	9.00
10.00	01000	DIETARY	6,186	6,186	0	126	27,180 10.00
11.00	01100	CAFETERIA	2,242	2,242	0	504	0 11.00
13.00	01300	NURSING ADMINISTRATION	3,652	3,652	0	504	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,839	1,839	0	378	0 14.00
15.00	01500	PHARMACY	1,540	1,540	0	315	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,680	2,680	0	315	0 16.00
17.00	01700	SOCIAL SERVICE	475	475	0	189	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,707	32,707	73,503	11,942	24,689 30.00
40.00	04000	SUBPROVIDER - IPF	7,534	7,534	5,430	787	2,491 40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,288	14,288	4,833	5,356	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,799	3,799	24,163	1,953	0 54.00
60.00	06000	LABORATORY	3,905	3,905	0	946	0 60.00
65.00	06500	RESPIRATORY THERAPY	3,593	3,593	1,611	946	0 65.00
66.00	06600	PHYSICAL THERAPY	3,094	3,094	8,054	1,071	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,084	5,084	0	1,260	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	10,958	10,958	43,493	6,301	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,474	106,863	161,087	32,893	27,180 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	945	0 192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	298	298	0	189	0 194.01
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)	1,830,072	3,916,243	226,070	1,767,282	1,047,721 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.102210	36.545413	1.403403	51.937638	38.547498 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	112,487	375,669	22,397	49,360	123,381 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.866805	3.505650	0.139037	1.450613	4.539404 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: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	27,281					11.00
13.00	01300	NURSING ADMINISTRATION	816	241,905				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	195	3,129	1,203,748			14.00
15.00	01500	PHARMACY	736	0	817	507,347		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	0	296	0	24,220	16.00
17.00	01700	SOCIAL SERVICE	223	0	36	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,820	121,722	159,629	5,584	19,383	30.00
40.00	04000	SUBPROVIDER - IPF	825	13,235	89	0	1,920	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,846	29,596	138,224	7,343	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	15,897	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,418	0	26,094	22,359	0	54.00
60.00	06000	LABORATORY	2,003	0	259,749	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,228	0	22,673	2,238	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,110	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	147,508	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	203,238	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	428,265	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	228	20	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	889	14,238	1,415	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,764	44,318	164,241	15,549	2,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	15,667	14,396	34	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,273	241,905	1,159,640	481,392	24,220	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	2,812	0	42,831	25,955	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	215	0	92	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	981	0	1,185	0	0	194.01
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)	956,166	1,822,261	293,574	947,939	1,207,611	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.048789	7.532961	0.243883	1.868423	49.860074	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,812	79,976	39,043	124,252	59,565	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.752575	0.330609	0.032435	0.244905	2.459331	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: 14-0077

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

Worksheet B-1

Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description			SOCIAL SERVICE	
			(TIME SPENT)	
			17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	223,109	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	121,722	30.00
40.00	04000	SUBPROVIDER - IPF	13,235	40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	29,596	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	14,238	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	44,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,109	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONREIMBURSABLE - GRANT	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - TRANSPORTATI	0	194.01
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)	227,936	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.021635	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,718	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.048039	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,981,719		21,981,719	9,292	21,991,011	30.00	
40.00	04000	SUBPROVIDER - IPF	2,619,826		2,619,826	3,320	2,623,146	40.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,181,004		4,181,004	0	4,181,004	50.00	
53.00	05300	ANESTHESIOLOGY	26,693		26,693	0	26,693	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,418,456		3,418,456	0	3,418,456	54.00	
60.00	06000	LABORATORY	4,835,049		4,835,049	0	4,835,049	60.00	
65.00	06500	RESPIRATORY THERAPY	1,895,372	0	1,895,372	4,349	1,899,721	65.00	
66.00	06600	PHYSICAL THERAPY	864,814	0	864,814	0	864,814	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	227,450		227,450	0	227,450	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	313,382		313,382	0	313,382	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,093,426		2,093,426	0	2,093,426	73.00	
74.00	07400	RENAL DIALYSIS	17,579		17,579	0	17,579	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,620,681		1,620,681	3,632	1,624,313	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	6,426,720		6,426,720	0	6,426,720	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,056,187		3,056,187		3,056,187	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,829,565		1,829,565		1,829,565	101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	55,407,923	0	55,407,923	20,593	55,428,516	200.00	
201.00		Less Observation Beds	3,056,187		3,056,187		3,056,187	201.00	
202.00		Total (see instructions)	52,351,736	0	52,351,736	20,593	52,372,329	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,747,503		10,747,503			30.00	
40.00	04000	SUBPROVIDER - IPF	1,251,732		1,251,732			40.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112,706	1,947,558	2,060,264	2.029354	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	34,502	624,511	659,013	0.040505	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,336	6,172,346	6,766,682	0.505189	0.000000	54.00	
60.00	06000	LABORATORY	1,883,098	13,673,332	15,556,430	0.310807	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	335,551	1,326,861	1,662,412	1.140134	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	22,464	1,196,802	1,219,266	0.709291	0.000000	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,699	478,211	531,910	0.427610	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,041	88,554	93,595	3.348277	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	412,759	562,573	975,332	2.146373	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	3,245	1,298	4,543	3.869470	0.000000	74.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,414	1,089,533	1,091,947	1.484212	0.000000	76.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
91.00	09100	EMERGENCY	1,071,373	8,057,460	9,128,833	0.704002	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,225	814,528	830,753	3.678815	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,204,897	1,204,897			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	16,546,648	37,238,464	53,785,112			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	16,546,648	37,238,464	53,785,112			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 7/27/2022 12:21 pm
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2.029354			50.00
53.00	05300	ANESTHESIOLOGY	0.040505			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.505189			54.00
60.00	06000	LABORATORY	0.310807			60.00
65.00	06500	RESPIRATORY THERAPY	1.142750			65.00
66.00	06600	PHYSICAL THERAPY	0.709291			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427610			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3.348277			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2.146373			73.00
74.00	07400	RENAL DIALYSIS	3.869470			74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.487538			76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.704002			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.678815			92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY				101.00
	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: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	958,677	0	958,677	8,131	117.90	30.00
40.00	SUBPROVIDER - IPF	178,560	0	178,560	764	233.72	40.00
200.00	Total (lines 30 through 199)	1,137,237		1,137,237	8,895		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	936	110,354				
40.00	SUBPROVIDER - IPF	0	0				
200.00	Total (lines 30 through 199)	936	110,354				

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0077		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/27/2022 12:21 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	8,131	0.00	936	30.00		
40.00	04000	SUBPROVIDER - IPF	0	0	764	0.00	0	40.00		
200.00		Total (lines 30 through 199)	0	0	8,895		936	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
40.00	04000	SUBPROVIDER - IPF	0							40.00
200.00		Total (lines 30 through 199)	0							200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,353,708	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	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)		13,580	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	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)		123.90	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)		27.04	30.00
31.00	Percentage of Medicaid patient days (see instructions)		58.41	31.00
32.00	Sum of lines 30 and 31		85.45	32.00
33.00	Allowable disproportionate share percentage (see instructions)		59.71	33.00
34.00	Disproportionate share adjustment (see instructions)		202,075	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000122775	0.000120884	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,017,808	869,397	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	761,264	219,136	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	980,400		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,549,763		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		2,549,763	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		125,806	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		0	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)		2,675,569	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,675,569	61.00
62.00	Deductibles billed to program beneficiaries		207,532	62.00
63.00	Coinsurance billed to program beneficiaries		25,133	63.00
64.00	Allowable bad debts (see instructions)		96,248	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		62,561	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		96,248	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,505,465	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)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,505,465	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		2,088,040	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)		417,425	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	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	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,784	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,276,057	2.00
3.00	OPPS payments		502,924	3.00
4.00	Outlier payment (see instructions)		6,418	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,784	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,763	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,763	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,763	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		2,021	20.00
21.00	Lesser of cost or charges (see instructions)		1,763	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)		509,342	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)		113,635	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)		397,470	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)		397,470	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		397,470	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)		24,068	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		15,644	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,068	36.00
37.00	Subtotal (see instructions)		413,114	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)		413,114	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		429,222	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)		-16,108	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077 Component CCN: 14-S077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,229	2.00
3.00	OPPS payments		350	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		350	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)		70	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)		280	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)		280	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		280	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)		280	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		280	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		280	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)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077 Component CCN: 14-S077	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS			200.00
	Part B Combined Billed Days			

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
7/27/2022 12:21 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,088,040		429,222	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,088,040		429,222	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		417,425		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		16,108	6.02
7.00	Total Medicare program liability (see instructions)		2,505,465		413,114	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: 14-0077

Period:

Worksheet E-1

Component CCN: 14-S077

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		280	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		280	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		280	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077 Component CCN: 14-S077	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		0	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		2.093151	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		0	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		0	18.00
19.00	Deductibles		0	19.00
20.00	Subtotal (line 18 minus line 19)		0	20.00
21.00	Coinsurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		0	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.98	Recovery of accelerated depreciation.		0	30.98
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		0	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		0	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

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

Provider CCN: 14-0077

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

Worksheet G

Date/Time Prepared:
7/27/2022 12:21 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	10,842,575	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	4,027,884	0	0	0	4.00
5.00 Other receivable	1,433,624	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	575,597	0	0	0	7.00
8.00 Prepaid expenses	766,795	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)	17,646,475	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,192,647	0	0	0	12.00
13.00 Land improvements	307,583	0	0	0	13.00
14.00 Accumulated depreciation	-297,107	0	0	0	14.00
15.00 Buildings	31,053,035	0	0	0	15.00
16.00 Accumulated depreciation	-18,360,358	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	847,179	0	0	0	19.00
20.00 Accumulated depreciation	-346,650	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	16,585,947	0	0	0	23.00
24.00 Accumulated depreciation	-13,195,488	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	548,582	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	19,335,370	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	1,106,814	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,106,814	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	38,088,659	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	3,507,828	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,680,792	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	921,604	0	0	0	40.00
41.00 Deferred income	759,040	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	4,361,993	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	11,231,257	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	6,239,721	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	3,125,752	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	9,365,473	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	20,596,730	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	17,491,929	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)	17,491,929	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	38,088,659	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0077

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

Worksheet G-1

Date/Time Prepared:
7/27/2022 12:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,020,469		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,453,456				2.00
3.00	Total (sum of line 1 and line 2)		17,473,925		0		3.00
4.00	TRANSFERS TO/FROM RELATED PARTY	18,004		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)		18,004		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,491,929		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,491,929		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	TRANSFERS TO/FROM RELATED PARTY		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0077

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/27/2022 12:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,747,503		10,747,503	1.00
2.00	SUBPROVIDER - IPF	1,251,732		1,251,732	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,999,235		11,999,235	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,999,235		11,999,235	17.00
18.00	Ancillary services	3,459,817	27,161,577	30,621,394	18.00
19.00	Outpatient services	1,087,598	8,871,988	9,959,586	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		1,204,897	1,204,897	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 PRIVATE OFFICES	1,920,549	10,950,189	12,870,738	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,467,199	48,188,651	66,655,850	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,974,903		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)		70,974,903		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0077

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

Worksheet G-3

Date/Time Prepared:
7/27/2022 12:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,655,850	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,835,843	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,820,007	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,974,903	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,154,896	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	27,630	6.00
7.00	Income from investments	2,725	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	1,239	10.00
11.00	Rebates and refunds of expenses	10,879	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	237,731	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	108	17.00
18.00	Revenue from sale of medical records and abstracts	20,422	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	4,293	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	2,675,054	24.00
24.01	MISC INCOME	439,554	24.01
24.02	INSURANCE PROCEEDS	22,268	24.02
24.50	COVID-19 PHE Funding	20,166,449	24.50
25.00	Total other income (sum of lines 6-24)	23,608,352	25.00
26.00	Total (line 5 plus line 25)	7,453,456	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,453,456	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-0077 HHA CCN: 14-7315	Period: From 01/01/2021 To 12/31/2021	Worksheet H Date/Time Prepared: 7/27/2022 12:21 pm
						Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur chased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		15,996	15,996	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	413,854	29,299	23,507	0	631,517	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	186,746	13,221	10,607	0	210,574	6.00
7.00	Physical Therapy	0	0	0	183,322	183,322	7.00
8.00	Occupational Therapy	0	0	0	90,323	90,323	8.00
9.00	Speech Pathology	0	0	0	30,526	30,526	9.00
10.00	Medical Social Services	6,712	475	381	0	7,568	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	607,312	42,995	34,495	304,171	1,169,826	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	15,996	0	15,996		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	631,517	0	631,517		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	210,574	0	210,574		6.00
7.00	Physical Therapy	0	183,322	0	183,322		7.00
8.00	Occupational Therapy	0	90,323	0	90,323		8.00
9.00	Speech Pathology	0	30,526	0	30,526		9.00
10.00	Medical Social Services	0	7,568	0	7,568		10.00
11.00	Home Health Aide	0	0	0	0		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	1,169,826	0	1,169,826		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0077

Period:

Worksheet H-1

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/27/2022 12:21 pmHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures					Movable Equipment
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	15,996	15,996				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	631,517	15,996	0	0	0	647,513	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	210,574	0	0	0	0	210,574	6.00
7.00	Physical Therapy	183,322	0	0	0	0	183,322	7.00
8.00	Occupational Therapy	90,323	0	0	0	0	90,323	8.00
9.00	Speech Pathology	30,526	0	0	0	0	30,526	9.00
10.00	Medical Social Services	7,568	0	0	0	0	7,568	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,169,826	15,996	0	0	0	1,169,826	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	647,513						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	261,049	471,623					6.00
7.00	Physical Therapy	227,265	410,587					7.00
8.00	Occupational Therapy	111,974	202,297					8.00
9.00	Speech Pathology	37,843	68,369					9.00
10.00	Medical Social Services	9,382	16,950					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,169,826					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-1

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
7/27/2022 12:21 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	15,996			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	15,996	0	0	0	-647,513	522,313
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	210,574
7.00	Physical Therapy	0	0	0	0	0	183,322
8.00	Occupational Therapy	0	0	0	0	0	90,323
9.00	Speech Pathology	0	0	0	0	0	30,526
10.00	Medical Social Services	0	0	0	0	0	7,568
11.00	Home Health Aide	0	0	0	0	0	0
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	15,996	0	0	0	-647,513	522,313
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	15,996	0	0	0		647,513
26.00	Unit Cost Multiplier	1.000000	0.000000	0.000000	0.000000		1.239703

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/27/2022 12:21 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00			2.00	
1.00	Administrative and General	0	0	0	99,464	99,464	29,647	1.00
2.00	Skilled Nursing Care	471,623	0	0	44,881	516,504	153,951	2.00
3.00	Physical Therapy	410,587	0	0	0	410,587	122,381	3.00
4.00	Occupational Therapy	202,297	0	0	0	202,297	60,297	4.00
5.00	Speech Pathology	68,369	0	0	0	68,369	20,378	5.00
6.00	Medical Social Services	16,950	0	0	1,613	18,563	5,533	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,169,826	0	0	145,958	1,315,784	392,187	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/27/2022 12:21 pmHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	78,185	3,511	64	0	0	210,871	1.00
2.00	Skilled Nursing Care	38,727	0	0	0	0	709,182	2.00
3.00	Physical Therapy	0	0	0	0	0	532,968	3.00
4.00	Occupational Therapy	0	0	0	0	0	262,594	4.00
5.00	Speech Pathology	0	0	0	0	0	88,747	5.00
6.00	Medical Social Services	1,107	0	0	0	0	25,203	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	118,019	3,511	64	0	0	1,829,565	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	210,871					1.00
2.00	Skilled Nursing Care	0	709,182	92,387	801,569			2.00
3.00	Physical Therapy	0	532,968	69,431	602,399			3.00
4.00	Occupational Therapy	0	262,594	34,209	296,803			4.00
5.00	Speech Pathology	0	88,747	11,561	100,308			5.00
6.00	Medical Social Services	0	25,203	3,283	28,486			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	1,829,565	210,871	1,829,565			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.130272				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
7/27/2022 12:21 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	0	413,854	0	99,464	0	1.00
2.00	Skilled Nursing Care	0	0	186,746	0	516,504	0	2.00
3.00	Physical Therapy	0	0	0	0	410,587	0	3.00
4.00	Occupational Therapy	0	0	0	0	202,297	0	4.00
5.00	Speech Pathology	0	0	0	0	68,369	0	5.00
6.00	Medical Social Services	0	0	6,712	0	18,563	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	607,312		1,315,784	0	20.00
21.00	Total cost to be allocated	0	0	145,958		392,187	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.240334		0.298063	0.000000	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	10,379	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	5,141	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	147	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	15,667	20.00
21.00	Total cost to be allocated	0	0	0	0	0	118,019	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	7.532967	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0077

Period:

Worksheet H-2

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
7/27/2022 12:21 pmHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	14,396	34	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	14,396	34	0	0			20.00
21.00	Total cost to be allocated	3,511	64	0	0			21.00
22.00	Unit cost multiplier	0.243887	1.882353	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	801,569		801,569	1,698	472.07	1.00
2.00	Physical Therapy	3.00	602,399	0	602,399	2,192	274.82	2.00
3.00	Occupational Therapy	4.00	296,803	0	296,803	1,080	274.82	3.00
4.00	Speech Pathology	5.00	100,308	0	100,308	365	274.82	4.00
5.00	Medical Social Services	6.00	28,486		28,486	44	647.41	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		1,829,565	0	1,829,565	5,379		7.00

7.00	Total (Sum of lines 1-6)		1,520,500	0	2,705,500	0,000	7.00
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
				0	1.00	2.00	3.00

Limitation Cost Computation

8.00	Skilled Nursing Care		41180	0	171		8.00
9.00	Physical Therapy		41180	0	275		9.00
10.00	Occupational Therapy		41180	0	129		10.00
11.00	Speech Pathology		41180	0	27		11.00
12.00	Medical Social Services		41180	0	4		12.00
13.00	Home Health Aide		41180	0	0		13.00
14.00	Total (sum of lines 8-13)			0	606		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		Part B					
		Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	6.00	7.00	8.00	9.00	10.00	11.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	0	171	0	80,724		1.00
2.00	Physical Therapy	0	275	0	75,576		2.00
3.00	Occupational Therapy	0	129	0	35,452		3.00
4.00	Speech Pathology	0	27	0	7,420		4.00
5.00	Medical Social Services	0	4	0	2,590		5.00
6.00	Home Health Aide	0	0	0	0		6.00
7.00	Total (sum of lines 1-6)	0	606	0	201,762		7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
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Limitation Cost Computation

8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/27/2022 12:21 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation								
1.00	Skilled Nursing Care	80,724						1.00
2.00	Physical Therapy	75,576						2.00
3.00	Occupational Therapy	35,452						3.00
4.00	Speech Pathology	7,420						4.00
5.00	Medical Social Services	2,590						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	201,762						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0077

Period:

Worksheet H-3

HHA CCN: 14-7315

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
7/27/2022 12:21 pm

Title XVIII

Home Health
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.709291	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.427610	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	2.146373	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0077 HHA CCN: 14-7315	Period: From 01/01/2021 To 12/31/2021	Worksheet H-4 Part I-II Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	83,242
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	24,185
13.00	Total PPS Reimbursement - LUPA Episodes		0	3,320
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	7,797
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	118,544
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	118,544
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	118,544
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	118,544
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	118,544
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	118,544
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0077

Period:

Worksheet H-5

HHA CCN: 14-7315

From 01/01/2021

Date/Time Prepared:

To 12/31/2021

7/27/2022 12:21 pm

Home Health
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PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		118,544	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			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			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. H-4, Part II, column as appropriate, line 32)		0		118,544	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		118,544	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0077	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 7/27/2022 12:21 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		104,973	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,004	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)		19.18	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)		27.04	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		58.41	8.00
9.00	Sum of lines 7 and 8		85.45	9.00
10.00	Allowable disproportionate share percentage (see instructions)		18.89	10.00
11.00	Disproportionate share adjustment (see instructions)		19,829	11.00
12.00	Total prospective capital payments (see instructions)		125,806	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