

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: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 3:15 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/29/2021	Time: 3:15 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWESTERN REGIONAL MEDICAL CENTER (14-0100) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) R. LEE PIEKARZ
Officer or Administrator of Provider(s)

REGIONAL CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-6,502	-33,225	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
200.00	Total	0	-6,502	-33,225	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: 14-0100		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:15 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2501 EMMAUS AVENUE			PO Box:				1.00			
2.00	City: ZION			State: IL		Zip Code: 60099		County: LAKE			
		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		MIDWESTERN REGIONAL MEDICAL CENTER		140100	29404	1	07/01/1967	N	P	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)						4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	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)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0100		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:15 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)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 07/01/2020
To 06/30/2021Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:15 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	133,056	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		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	14H130	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0100		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:15 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: CTCA	Contractor's Name: FCSO		Contractor's Number: 09001						
142.00	Street: 5900 BROKEN SOUND PARKWAY NW	PO Box:								
143.00	City: BOCA RATON	State: FL		Zip Code: 33487						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								N	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.									146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF	N	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	N	N	161.00	
								1.00		
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		166.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.99	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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0100		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 3:15 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			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.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	10/15/2021	Y	10/15/2021
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: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 3:15 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	FRANCES	HAYNES	41.00
42.00	Enter the employer/company name of the cost report preparer	CANCER TREATMENT CENTERS OF AMERICA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-342-6461	FRANCES.HAYNES@CTCA-HOPE.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 3:15 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.	MANAGER, REVENUE INTEGRITY	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 3:15 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	73	26,645	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)		73	26,645	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		73	26,645	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		73			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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 3:15 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)	1,393	3	4,699			1.00
2.00	HMO and other (see instructions)	0	0				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)	1,393	3	4,699			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,393	3	4,699	0.00	539.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
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	539.75	27.00
28.00	Observation Bed Days		0	643			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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 3:15 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	242	13	950	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	242	13	950	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 3:15 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	39,247,863	0	39,247,863	1,122,680.81	34.96
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,457,186	12,103	2,469,289	85,437.56	28.90
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		750,512	0	750,512	10,285.00	72.97
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		15,324,179	0	15,324,179	358,501.00	42.75
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)		10,773,851	0	10,773,851		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		723,349	0	723,349		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		7,346,975	0	7,346,975		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 3:15 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	
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,506,625	-1,015,376	491,249	9,806.00	50.10	26.00
27.00	Administrative & General	5.00	3,980,592	565,301	4,545,893	118,422.00	38.39	27.00
28.00	Administrative & General under contract (see inst.)		189,233	0	189,233	686.18	275.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,098,802	20,517	1,119,319	38,183.00	29.31	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	991,199	10,466	1,001,665	64,676.00	15.49	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	901,616	-834,590	67,026	3,843.00	17.44	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	845,014	845,014	48,446.00	17.44	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,219,505	132,573	1,352,078	24,225.00	55.81	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,231,880	21,050	2,252,930	53,574.00	42.05	40.00
41.00	Medical Records & Medical Records Library	16.00	941,968	443	942,411	30,561.00	30.84	41.00
42.00	Social Service	17.00	204,132	10,096	214,228	6,259.00	34.23	42.00
43.00	Other General Service	18.00	791,495	15,372	806,867	20,257.00	39.83	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/29/2021 3:15 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)	39,437,096	0	39,437,096	1,123,366.99	35.11	1.00
2.00	Excluded area salaries (see instructions)	2,457,186	12,103	2,469,289	85,437.56	28.90	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,979,910	-12,103	36,967,807	1,037,929.43	35.62	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,074,691	0	16,074,691	368,786.00	43.59	4.00
5.00	Subtotal wage-related costs (see inst.)	18,120,826	0	18,120,826	0.00	49.02	5.00
6.00	Total (sum of lines 3 thru 5)	71,175,427	-12,103	71,163,324	1,406,715.43	50.59	6.00
7.00	Total overhead cost (see instructions)	14,057,047	-229,134	13,827,913	418,938.18	33.01	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/29/2021 3:15 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,409,904	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)	5,757,589	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	316,830	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,634	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	194,277	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	599,576	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	5,331	14.00
15.00	'Workers' Compensation Insurance	96,780	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,819,594	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	285,685	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,497,200	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/29/2021 3:15 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	750,512	11,497,200	1.00
2.00	Hospital	750,512	11,497,200	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		MIDWESTERN REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/29/2021 3:15 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)		0.213725	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		-15,539	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	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		0	5.00	
6.00	Medicaid charges		2,403,004	6.00	
7.00	Medicaid cost (line 1 times line 6)		513,582	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)		529,121	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		529,121	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)	92,429	1,266,546	1,358,975	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	19,754	1,266,546	1,286,300	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)	19,754	1,266,546	1,286,300	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,764,485	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		176,029	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		270,814	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		4,493,671	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,055,195	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,341,495	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,870,616	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 3:15 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		18,453,774	18,453,774	-47,119	18,406,655
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,584,162	3,584,162	0	3,584,162
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,506,625	7,445,142	8,951,767	-785,271	8,166,496
5.00	00500	ADMINISTRATIVE & GENERAL	3,980,592	101,034,305	105,014,897	-142,982	104,871,915
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	1,098,802	3,473,843	4,572,645	20,517	4,593,162
8.00	00800	LAUNDRY & LINEN SERVICE	0	-28,826	-28,826	0	-28,826
9.00	00900	HOUSEKEEPING	991,199	832,371	1,823,570	10,466	1,834,036
10.00	01000	DIETARY	901,616	1,387,036	2,288,652	-2,119,693	168,959
11.00	01100	CAFETERIA	0	0	0	2,130,117	2,130,117
13.00	01300	NURSING ADMINISTRATION	1,219,505	262,743	1,482,248	132,573	1,614,821
14.00	01400	CENTRAL SERVICES & SUPPLY	0	845,873	845,873	0	845,873
15.00	01500	PHARMACY	2,231,880	819,522	3,051,402	21,050	3,072,452
16.00	01600	MEDICAL RECORDS & LIBRARY	941,968	133,575	1,075,543	443	1,075,986
17.00	01700	SOCIAL SERVICE	204,132	33,788	237,920	10,096	248,016
18.00	01850	OTHER GENERAL SERVICES	791,495	149,562	941,057	15,372	956,429
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,745,924	992,212	4,738,136	16,762	4,754,898
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,248,406	7,210,026	10,458,432	26,528	10,484,960
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,744,270	2,139,181	3,883,451	35,820	3,919,271
55.00	05500	RADIOLOGY-THERAPEUTIC	1,316,372	3,311,337	4,627,709	20,619	4,648,328
56.00	05600	RADIOISOTOPE	554,396	4,233,259	4,787,655	5,261	4,792,916
57.00	05700	CT SCAN	512,565	508,771	1,021,336	5,241	1,026,577
58.00	05800	MRI	374,944	488,047	862,991	176	863,167
60.00	06000	LABORATORY	1,696,140	3,371,091	5,067,231	30,798	5,098,029
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,066,141	1,066,141	0	1,066,141
64.00	06400	INTRAVENOUS THERAPY	1,379,861	375,797	1,755,658	649	1,756,307
65.00	06500	RESPIRATORY THERAPY	810,642	483,380	1,294,022	10,381	1,304,403
66.00	06600	PHYSICAL THERAPY	833,720	130,110	963,830	10,392	974,222
69.00	06900	ELECTROCARDIOLOGY	275,645	85,602	361,247	5,130	366,377
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67,633,848	67,633,848	0	67,633,848
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0
76.01	03951	HOSPITAL NUTRITION	374,937	50,440	425,377	6,426	431,803
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0
76.03	03954	INFUSION CENTER	0	0	0	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,300,194	827,576	6,127,770	42,493	6,170,263
91.00	09100	EMERGENCY	754,847	203,294	958,141	355	958,496
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		125,733	125,733	-337,569	-211,836
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,790,677	231,662,715	268,453,392	-874,969	267,578,423
	NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	297,942	-44,938	253,004	140	253,144
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	2,159,244	6,846,264	9,005,508	874,829	9,880,337
200.00		TOTAL (SUM OF LINES 118 through 199)	39,247,863	238,464,041	277,711,904	0	277,711,904

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,812,211	16,594,444	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,921,125	9,505,287	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-135,352	8,031,144	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-60,189,422	44,682,493	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,593,162	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-28,826	8.00
9.00	00900	HOUSEKEEPING	0	1,834,036	9.00
10.00	01000	DIETARY	0	168,959	10.00
11.00	01100	CAFETERIA	-360,821	1,769,296	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,614,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	845,873	14.00
15.00	01500	PHARMACY	0	3,072,452	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,729	1,071,257	16.00
17.00	01700	SOCIAL SERVICE	0	248,016	17.00
18.00	01850	OTHER GENERAL SERVICES	-2,463	953,966	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,754,898	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	10,484,960	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,919,271	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-9	4,648,319	55.00
56.00	05600	RADIOISOTOPE	0	4,792,916	56.00
57.00	05700	CT SCAN	0	1,026,577	57.00
58.00	05800	MRI	0	863,167	58.00
60.00	06000	LABORATORY	0	5,098,029	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,066,141	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,756,307	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,304,403	65.00
66.00	06600	PHYSICAL THERAPY	-3,175	971,047	66.00
69.00	06900	ELECTROCARDIOLOGY	0	366,377	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67,633,848	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	431,803	76.01
76.02	03952	PAIN MANAGEMENT	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	6,170,263	90.00
91.00	09100	EMERGENCY	0	958,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	211,836	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-56,375,221	211,203,202	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	253,144	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	9,880,337	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-56,375,221	221,336,683	200.00

RECLASSIFICATIONS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/29/2021 3:15 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	845,014	1,285,103		1.00
	0		845,014	1,285,103		
	B - EMPLOYEE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	556,248	0		1.00
2.00	OPERATION OF PLANT	7.00	20,517	0		2.00
3.00	HOUSEKEEPING	9.00	10,466	0		3.00
4.00	DIETARY	10.00	10,424	0		4.00
5.00	NURSING ADMINISTRATION	13.00	132,573	0		5.00
6.00	PHARMACY	15.00	21,050	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	443	0		7.00
8.00	SOCIAL SERVICE	17.00	10,096	0		8.00
9.00	OTHER GENERAL SERVICES	18.00	15,372	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	16,762	0		10.00
12.00	OPERATING ROOM	50.00	26,528	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	35,820	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	20,619	0		14.00
15.00	RADIOISOTOPE	56.00	5,261	0		15.00
16.00	CT SCAN	57.00	5,241	0		16.00
17.00	MRI	58.00	176	0		17.00
18.00	LABORATORY	60.00	30,798	0		18.00
19.00	INTRAVENOUS THERAPY	64.00	649	0		19.00
20.00	RESPIRATORY THERAPY	65.00	10,381	0		20.00
21.00	PHYSICAL THERAPY	66.00	10,392	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	5,130	0		22.00
23.00	HOSPITAL NUTRITION	76.01	6,426	0		23.00
24.00	CLINIC	90.00	42,493	0		24.00
25.00	EMERGENCY	91.00	355	0		25.00
26.00	RESEARCH	191.00	140	0		26.00
27.00	OTHER NONREIMBURSABLE	194.00	21,016	0		27.00
	EXPENSES					
	0		1,015,376	0		
	C - PROPERTY TAX					
1.00	OTHER NONREIMBURSABLE	194.00	0	860,930		1.00
	EXPENSES					
	0		0	860,930		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	337,569		1.00
	0		0	337,569		
	E - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	483,807		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	230,105		2.00
	0		0	713,912		
	F - TRANSPORTATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	9,053	5,629		1.00
	0		9,053	5,629		
	G - GUEST ACCOMODATIONS DEPRECIATION					
1.00	OTHER NONREIMBURSABLE	194.00	0	7,565		1.00
	EXPENSES					
	0		0	7,565		
500.00	Grand Total: Increases		1,869,443	3,210,708		500.00

RECLASSIFICATIONS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/29/2021 3:15 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	845,014	1,285,103	0	1.00
	0		845,014	1,285,103		
B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,015,376	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
	0		1,015,376	0		
C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	860,930	13	1.00
	0		0	860,930		
D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	337,569	11	1.00
	0		0	337,569		
E - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	713,912	12	1.00
2.00		0.00	0	0	0	2.00
	0		0	713,912		
F - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE EXPENSES	194.00	9,053	5,629	0	1.00
	0		9,053	5,629		
G - GUEST ACCOMODATIONS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,565	9	1.00
	0		0	7,565		
500.00	Grand Total: Decreases		1,869,443	3,210,708		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 3:15 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	0	0	0	0	0	1.00
2.00	Land Improvements	1,126,605	0	0	0	0	2.00
3.00	Buildings and Fixtures	22,039,073	0	0	0	0	3.00
4.00	Building Improvements	183,241,850	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	96,166,757	2,924,396	0	2,924,396	2,986,122	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	302,574,285	2,924,396	0	2,924,396	2,986,122	8.00
9.00	Reconciling Items	95,993	139,505	0	139,505	0	9.00
10.00	Total (line 8 minus line 9)	302,478,292	2,784,891	0	2,784,891	2,986,122	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	1,126,605	0				2.00
3.00	Buildings and Fixtures	22,039,073	0				3.00
4.00	Building Improvements	183,241,850	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	96,105,031	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	302,512,559	0				8.00
9.00	Reconciling Items	235,498	0				9.00
10.00	Total (line 8 minus line 9)	302,277,061	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 3:15 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	11,023,573	0	0	0	4,701,488	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,335,412	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,358,985	0	0	0	4,701,488	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	2,728,713	18,453,774				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,248,750	3,584,162				2.00
3.00	Total (sum of lines 1-2)	4,977,463	22,037,936				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 3:15 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	206,407,528	31,071,899	175,335,629	0.780626	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	96,105,031	46,831,740	49,273,291	0.219374	0	2.00
3.00	Total (sum of lines 1-2)	302,512,559	77,903,639	224,608,920	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,811,654	-2,432,076	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,256,537	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,068,191	-2,432,076	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	337,569	308,026	3,840,558	2,728,713	16,594,444	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,248,750	9,505,287	2.00
3.00	Total (sum of lines 1-2)	337,569	308,026	3,840,558	4,977,463	26,099,731	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2		0		0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-40,548,684			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-360,821	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-31,236	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	2,503,491	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & 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	OTHER REVENUE	B	-47,431	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE	B	-4,667	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	OTHER REVENUE	B	-2,463	OTHER GENERAL SERVICES	18.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.03	OTHER REVENUE	B		0 INTRAVENOUS THERAPY	64.00	0	33.03
33.04	OTHER REVENUE	B	-3,175	0 PHYSICAL THERAPY	66.00	0	33.04
33.05	OTHER REVENUE	B		0 ADULTS & PEDIATRICS	30.00	0	33.05
33.06	OTHER REVENUE	B		0 HOSPITAL NUTRITION	76.01	0	33.06
33.07	NON-ALLOWABLE EXPENSE	A	-62	0 MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08	NON-ALLOWABLE EXPENSE	A	-17,824,453	0 ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	NON-ALLOWABLE EXPENSE	A	-9	0 RADIOLOGY-THERAPEUTIC	55.00	0	33.09
33.10	NON-ALLOWABLE EXPENSE	A		0 PHARMACY	15.00	0	33.10
33.11	LOBBYING EXPENSE	A	-55,711	0 ADMINISTRATIVE & GENERAL	5.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-56,375,221				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: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 3:15 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	0.00			0	0	1.00
2.00	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	12,729	12,729	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	118,616	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	28,686	4.01
4.02	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	337,569	1,422	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	259,625	2,691,701	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	42,601,526	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	34,958,207	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE	308,026	483,807	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE	94,753	230,105	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	370,738	709,835	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	826,882	0	4.09
4.10	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	3,536,250	0	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	35,637,003	0	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			41,383,575	81,932,259	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	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
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: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 3:15 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	0	0		1.00
2.00	-95,625	0		2.00
3.00	0	9		3.00
4.00	-118,616	9		4.00
4.01	-28,686	0		4.01
4.02	336,147	0		4.02
4.03	-2,432,076	10		4.03
4.04	-42,601,526	0		4.04
4.05	-34,958,207	0		4.05
4.06	-175,781	12		4.06
4.07	-135,352	0		4.07
4.08	-339,097	0		4.08
4.09	826,882	9		4.09
4.10	3,536,250	9		4.10
4.11	35,637,003	0		4.11
5.00	-40,548,684			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	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
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.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:15 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	16,594,444	16,594,444			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,505,287		9,505,287		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,031,144	91,608	2,433	8,125,185	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,682,493	790,458	3,555,903	953,028	49,981,882
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	4,593,162	2,428,835	303,217	234,661	7,559,875
8.00	00800	LAUNDRY & LINEN SERVICE	-28,826	0	0	0	-28,826
9.00	00900	HOUSEKEEPING	1,834,036	227,693	16,217	209,995	2,287,941
10.00	01000	DIETARY	168,959	58,136	167,410	14,052	408,557
11.00	01100	CAFETERIA	1,769,296	732,771	0	177,154	2,679,221
13.00	01300	NURSING ADMINISTRATION	1,614,821	43,220	0	283,458	1,941,499
14.00	01400	CENTRAL SERVICES & SUPPLY	845,873	167,580	354,059	0	1,367,512
15.00	01500	PHARMACY	3,072,452	157,966	308,990	472,318	4,011,726
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071,257	176,161	0	197,573	1,444,991
17.00	01700	SOCIAL SERVICE	248,016	49,286	0	44,912	342,214
18.00	01850	OTHER GENERAL SERVICES	953,966	91,428	54	169,156	1,214,604
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,754,898	3,047,040	567,364	788,832	9,158,134
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,484,960	1,172,163	1,765,955	686,577	14,109,655
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,919,271	496,765	218,881	373,189	5,008,106
55.00	05500	RADIOLOGY-THERAPEUTIC	4,648,319	580,960	1,709,541	280,295	7,219,115
56.00	05600	RADIOISOTOPE	4,792,916	17,971	1,820	117,330	4,930,037
57.00	05700	CT SCAN	1,026,577	47,713	0	108,556	1,182,846
58.00	05800	MRI	863,167	66,763	6,840	78,642	1,015,412
60.00	06000	LABORATORY	5,098,029	392,264	249,845	362,046	6,102,184
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,066,141	13,119	52,649	0	1,131,909
64.00	06400	INTRAVENOUS THERAPY	1,756,307	428,970	48,191	289,418	2,522,886
65.00	06500	RESPIRATORY THERAPY	1,304,403	8,087	13,936	172,124	1,498,550
66.00	06600	PHYSICAL THERAPY	971,047	235,331	26,271	176,965	1,409,614
69.00	06900	ELECTROCARDIOLOGY	366,377	24,036	5,934	58,863	455,210
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	67,633,848	0	0	0	67,633,848
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0
76.01	03951	HOSPITAL NUTRITION	431,803	33,112	0	79,951	544,866
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0
76.03	03954	INFUSION CENTER	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,170,263	1,863,376	56,725	1,120,088	9,210,452
91.00	09100	EMERGENCY	958,496	103,334	27,728	158,325	1,247,883
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	211,203,202	13,546,146	9,459,963	7,607,508	207,591,903
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,354	0	0	47,354
191.00	19100	RESEARCH	253,144	112,319	953	62,492	428,908
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	9,880,337	2,888,625	44,371	455,185	13,268,518
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	221,336,683	16,594,444	9,505,287	8,125,185	221,336,683

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

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	49,981,882					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,204,739	0	9,764,614			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	-28,826		8.00
9.00	00900	HOUSEKEEPING	667,248	0	167,285	0	3,122,474	9.00
10.00	01000	DIETARY	119,150	0	42,712	0	13,904	10.00
11.00	01100	CAFETERIA	781,360	0	538,362	0	175,251	11.00
13.00	01300	NURSING ADMINISTRATION	566,213	0	31,754	0	10,337	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	398,817	0	123,120	0	40,079	14.00
15.00	01500	PHARMACY	1,169,968	0	116,056	0	37,780	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	421,413	0	129,425	0	42,131	16.00
17.00	01700	SOCIAL SERVICE	99,802	0	36,210	0	11,787	17.00
18.00	01850	OTHER GENERAL SERVICES	354,223	0	67,171	0	21,866	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,670,851	0	2,238,641	0	728,738	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,114,897	0	861,181	0	280,338	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,460,549	0	364,970	0	118,808	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,105,361	0	426,827	0	138,944	55.00
56.00	05600	RADIOISOTOPE	1,437,781	0	13,203	0	4,298	56.00
57.00	05700	CT SCAN	344,962	0	35,055	0	11,411	57.00
58.00	05800	MRI	296,132	0	49,050	0	15,967	58.00
60.00	06000	LABORATORY	1,779,623	0	288,194	0	93,815	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	330,107	0	9,638	0	3,138	63.00
64.00	06400	INTRAVENOUS THERAPY	735,767	0	315,161	0	102,594	64.00
65.00	06500	RESPIRATORY THERAPY	437,033	0	5,941	0	1,934	65.00
66.00	06600	PHYSICAL THERAPY	411,096	0	172,896	0	56,282	66.00
69.00	06900	ELECTROCARDIOLOGY	132,756	0	17,659	0	5,749	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,724,607	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	158,903	0	24,327	0	7,919	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,686,109	0	1,369,010	0	445,650	90.00
91.00	09100	EMERGENCY	363,929	0	75,919	0	24,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,973,396	0	7,519,767	0	2,393,434	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,810	0	34,791	0	11,325	190.00
191.00	19100	RESEARCH	125,085	0	82,520	0	26,863	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	3,869,591	0	2,127,536	0	690,852	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	-28,826	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,981,882	0	9,764,614	-28,826	3,122,474	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

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	584,323					10.00
11.00	01100	CAFETERIA	0	4,174,194				11.00
13.00	01300	NURSING ADMINISTRATION	0	120,480	2,670,283			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,929,528		14.00
15.00	01500	PHARMACY	0	266,444	0	0	5,601,974	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	151,992	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	31,128	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	0	100,746	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	345,470	462,898	1,468,235	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	441,920	522,079	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198,140	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	177,560	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	60,417	0	0	0	56.00
57.00	05700	CT SCAN	0	69,055	0	0	0	57.00
58.00	05800	MRI	0	47,605	0	0	0	58.00
60.00	06000	LABORATORY	0	265,594	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	238,853	166,793	441,889	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	110,698	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	109,822	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,966	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,929,528	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	5,601,974	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	54,329	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	796,827	0	0	0	90.00
91.00	09100	EMERGENCY	0	89,864	238,080	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	584,323	3,749,278	2,670,283	1,929,528	5,601,974	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	424,916	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	584,323	4,174,194	2,670,283	1,929,528	5,601,974	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	2,189,952					16.00
17.00	01700	SOCIAL SERVICE	0	521,141				17.00
18.00	01850	OTHER GENERAL SERVICES	0	0	1,758,610			18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,700	10,154	34,280	17,160,101	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	218,260	51,904	175,224	20,775,458	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,888	16,858	56,910	7,295,229	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	145,342	34,564	116,684	10,364,397	0	55.00
56.00	05600	RADIOISOTOPE	70,884	16,857	56,908	6,590,385	0	56.00
57.00	05700	CT SCAN	160,689	38,214	129,005	1,971,237	0	57.00
58.00	05800	MRI	40,954	9,739	32,879	1,507,738	0	58.00
60.00	06000	LABORATORY	143,661	34,164	115,335	8,822,570	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	13,285	3,159	10,666	1,501,902	0	63.00
64.00	06400	INTRAVENOUS THERAPY	49,522	11,777	39,757	4,624,999	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,396	2,948	9,952	2,079,452	0	65.00
66.00	06600	PHYSICAL THERAPY	6,660	1,584	5,347	2,173,301	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7,702	1,832	6,184	654,058	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,728	2,313	7,810	1,949,379	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	1,170,203	278,635	939,930	95,349,197	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,833	436	1,472	794,085	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	19,824	4,714	15,915	14,548,501	0	90.00
91.00	09100	EMERGENCY	5,421	1,289	4,352	2,051,451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,189,952	521,141	1,758,610	200,213,440	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	107,280	0	190.00
191.00	19100	RESEARCH	0	0	0	663,376	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	0	0	20,381,413	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	-28,826	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,189,952	521,141	1,758,610	221,336,683	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/29/2021 3:15 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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	17.00
18.00	01850	OTHER GENERAL SERVICES	18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	76.00
76.01	03951	HOSPITAL NUTRITION	76.01
76.02	03952	PAIN MANAGEMENT	76.02
76.03	03954	INFUSION CENTER	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	91,608	2,433	94,041	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	790,458	3,555,903	4,346,361	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,428,835	303,217	2,732,052	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	227,693	16,217	243,910	9.00
10.00	01000	DIETARY	0	58,136	167,410	225,546	10.00
11.00	01100	CAFETERIA	0	732,771	0	732,771	11.00
13.00	01300	NURSING ADMINISTRATION	0	43,220	0	43,220	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	167,580	354,059	521,639	14.00
15.00	01500	PHARMACY	0	157,966	308,990	466,956	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	176,161	0	176,161	16.00
17.00	01700	SOCIAL SERVICE	0	49,286	0	49,286	17.00
18.00	01850	OTHER GENERAL SERVICES	0	91,428	54	91,482	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,047,040	567,364	3,614,404	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,172,163	1,765,955	2,938,118	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	496,765	218,881	715,646	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	580,960	1,709,541	2,290,501	55.00
56.00	05600	RADIOISOTOPE	0	17,971	1,820	19,791	56.00
57.00	05700	CT SCAN	0	47,713	0	47,713	57.00
58.00	05800	MRI	0	66,763	6,840	73,603	58.00
60.00	06000	LABORATORY	0	392,264	249,845	642,109	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,119	52,649	65,768	63.00
64.00	06400	INTRAVENOUS THERAPY	0	428,970	48,191	477,161	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,087	13,936	22,023	65.00
66.00	06600	PHYSICAL THERAPY	0	235,331	26,271	261,602	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,036	5,934	29,970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	33,112	0	33,112	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,863,376	56,725	1,920,101	90.00
91.00	09100	EMERGENCY	0	103,334	27,728	131,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	13,546,146	9,459,963	23,006,109	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,354	0	47,354	190.00
191.00	19100	RESEARCH	0	112,319	953	113,272	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	2,888,625	44,371	2,932,996	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,594,444	9,505,287	26,099,731	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
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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	4,357,389					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	192,210	0	2,926,977			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	58,171	0	50,144	0	354,655	9.00
10.00	01000	DIETARY	10,388	0	12,803	0	1,579	10.00
11.00	01100	CAFETERIA	68,119	0	161,376	0	19,905	11.00
13.00	01300	NURSING ADMINISTRATION	49,363	0	9,518	0	1,174	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,769	0	36,906	0	4,552	14.00
15.00	01500	PHARMACY	101,998	0	34,788	0	4,291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,739	0	38,795	0	4,785	16.00
17.00	01700	SOCIAL SERVICE	8,701	0	10,854	0	1,339	17.00
18.00	01850	OTHER GENERAL SERVICES	30,881	0	20,135	0	2,484	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	232,846	0	671,041	0	82,772	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	358,738	0	258,142	0	31,841	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,331	0	109,401	0	13,494	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	183,546	0	127,943	0	15,781	55.00
56.00	05600	RADIOISOTOPE	125,346	0	3,958	0	488	56.00
57.00	05700	CT SCAN	30,074	0	10,508	0	1,296	57.00
58.00	05800	MRI	25,817	0	14,703	0	1,814	58.00
60.00	06000	LABORATORY	155,148	0	86,387	0	10,656	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	28,779	0	2,889	0	356	63.00
64.00	06400	INTRAVENOUS THERAPY	64,144	0	94,471	0	11,653	64.00
65.00	06500	RESPIRATORY THERAPY	38,101	0	1,781	0	220	65.00
66.00	06600	PHYSICAL THERAPY	35,839	0	51,826	0	6,393	66.00
69.00	06900	ELECTROCARDIOLOGY	11,574	0	5,293	0	653	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,719,550	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	13,853	0	7,292	0	899	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	234,176	0	410,365	0	50,618	90.00
91.00	09100	EMERGENCY	31,727	0	22,757	0	2,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,007,928	0	2,254,076	0	271,850	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,204	0	10,429	0	1,286	190.00
191.00	19100	RESEARCH	10,905	0	24,736	0	3,051	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	337,352	0	637,736	0	78,468	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,357,389	0	2,926,977	0	354,655	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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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	250,479					10.00
11.00	01100	CAFETERIA	0	984,221				11.00
13.00	01300	NURSING ADMINISTRATION	0	28,408	134,963			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	597,866		14.00
15.00	01500	PHARMACY	0	62,824	0	0	676,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,838	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,340	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	0	23,755	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	148,091	109,145	74,209	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	104,199	26,387	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,719	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	41,866	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	14,245	0	0	0	56.00
57.00	05700	CT SCAN	0	16,282	0	0	0	57.00
58.00	05800	MRI	0	11,225	0	0	0	58.00
60.00	06000	LABORATORY	0	62,624	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	102,388	39,328	22,334	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	26,101	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,895	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,358	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	597,866	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	676,323	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	12,810	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	187,880	0	0	0	90.00
91.00	09100	EMERGENCY	0	21,189	12,033	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,479	884,031	134,963	597,866	676,323	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	100,190	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,479	984,221	134,963	597,866	676,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE S	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	294,604					16.00
17.00	01700	SOCIAL SERVICE	0	78,040				17.00
18.00	01850	OTHER GENERAL SERVICES	0	0	170,694			18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,735	1,516	3,324	4,952,211	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,313	7,748	16,990	3,779,421	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,520	2,517	5,518	1,034,464	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19,520	5,160	11,314	2,698,875	0	55.00
56.00	05600	RADIOISOTOPE	9,520	2,516	5,518	182,740	0	56.00
57.00	05700	CT SCAN	21,581	5,705	12,509	146,924	0	57.00
58.00	05800	MRI	5,500	1,454	3,188	138,214	0	58.00
60.00	06000	LABORATORY	19,294	5,100	11,183	996,691	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,784	472	1,034	101,082	0	63.00
64.00	06400	INTRAVENOUS THERAPY	6,651	1,758	3,855	827,092	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,665	440	965	93,288	0	65.00
66.00	06600	PHYSICAL THERAPY	895	236	518	385,252	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,034	273	600	56,436	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,306	345	757	600,274	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	157,650	41,839	91,313	2,686,675	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	246	65	143	69,345	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,662	704	1,543	2,821,029	0	90.00
91.00	09100	EMERGENCY	728	192	422	224,749	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	294,604	78,040	170,694	21,794,762	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	60,273	0	190.00
191.00	19100	RESEARCH	0	0	0	152,687	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	0	0	0	4,092,009	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	294,604	78,040	170,694	26,099,731	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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	17.00
18.00	01850	OTHER GENERAL SERVICES	18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	76.00
76.01	03951	HOSPITAL NUTRITION	76.01
76.02	03952	PAIN MANAGEMENT	76.02
76.03	03954	INFUSION CENTER	76.03
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	369,359					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		9,505,283				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,039	2,433	38,756,616			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,594	3,555,899	4,545,893	-49,981,882	171,383,627	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,061	303,217	1,119,319	0	7,559,875	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	28,826	0	8.00
9.00	00900	HOUSEKEEPING	5,068	16,217	1,001,665	0	2,287,941	9.00
10.00	01000	DIETARY	1,294	167,410	67,026	0	408,557	10.00
11.00	01100	CAFETERIA	16,310	0	845,014	0	2,679,221	11.00
13.00	01300	NURSING ADMINISTRATION	962	0	1,352,079	0	1,941,499	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	354,059	0	0	1,367,512	14.00
15.00	01500	PHARMACY	3,516	308,990	2,252,930	0	4,011,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	942,412	0	1,444,991	16.00
17.00	01700	SOCIAL SERVICE	1,097	0	214,228	0	342,214	17.00
18.00	01850	OTHER GENERAL SERVICES	2,035	54	806,867	0	1,214,604	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,821	567,364	3,762,686	0	9,158,134	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,090	1,765,955	3,274,934	0	14,109,655	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	218,881	1,780,090	0	5,008,106	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	1,709,541	1,336,991	0	7,219,115	55.00
56.00	05600	RADIOISOTOPE	400	1,820	559,657	0	4,930,037	56.00
57.00	05700	CT SCAN	1,062	0	517,806	0	1,182,846	57.00
58.00	05800	MRI	1,486	6,840	375,120	0	1,015,412	58.00
60.00	06000	LABORATORY	8,731	249,845	1,726,938	0	6,102,184	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	52,649	0	0	1,131,909	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	48,191	1,380,510	0	2,522,886	64.00
65.00	06500	RESPIRATORY THERAPY	180	13,936	821,023	0	1,498,550	65.00
66.00	06600	PHYSICAL THERAPY	5,238	26,271	844,112	0	1,409,614	66.00
69.00	06900	ELECTROCARDIOLOGY	535	5,934	280,775	0	455,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	67,633,848	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	0	381,363	0	544,866	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,475	56,725	5,342,687	0	9,210,452	90.00
91.00	09100	EMERGENCY	2,300	27,728	755,202	0	1,247,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	301,510	9,459,959	36,287,327	-49,953,056	157,638,847	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	0	0	47,354	190.00
191.00	19100	RESEARCH	2,500	953	298,082	0	428,908	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	64,295	44,371	2,171,207	0	13,268,518	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,594,444	9,505,287	8,125,185		49,981,882	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.927683	1.000000	0.209646		0.291637	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			94,041		4,357,389	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002426		0.025425	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	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	349,726					6.00
7.00	00700	OPERATION OF PLANT	54,061	295,825				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	561,200			8.00
9.00	00900	HOUSEKEEPING	5,068	5,068	30,577	290,597		9.00
10.00	01000	DIETARY	1,294	1,294	0	1,294	25,638	10.00
11.00	01100	CAFETERIA	16,310	16,310	0	16,310	0	11.00
13.00	01300	NURSING ADMINISTRATION	962	962	0	962	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	3,730	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	1,097	1,097	0	1,097	0	17.00
18.00	01850	OTHER GENERAL SERVICES	2,035	2,035	1,138	2,035	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,821	67,821	105,762	67,821	15,158	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,090	26,090	78,460	26,090	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,057	11,057	204,472	11,057	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	0	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	1,062	1,062	0	1,062	0	57.00
58.00	05800	MRI	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	8,731	8,731	0	8,731	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,548	9,548	39,271	9,548	10,480	64.00
65.00	06500	RESPIRATORY THERAPY	180	180	0	180	0	65.00
66.00	06600	PHYSICAL THERAPY	5,238	5,238	10,650	5,238	0	66.00
69.00	06900	ELECTROCARDIOLOGY	535	535	11,216	535	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	41,475	41,475	53,914	41,475	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	15,591	2,300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	281,877	227,816	551,051	222,748	25,638	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	1,054	0	1,054	0	190.00
191.00	19100	RESEARCH	2,500	2,500	0	2,500	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	64,295	64,455	10,149	64,295	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	9,764,614	-28,826	3,122,474	584,323	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	33.008076	0.000000	10.745032	22.791286	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,926,977	0	354,655	250,479	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.894285	0.000000	1.220436	9.769834	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			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	839,306					11.00
13.00	01300	NURSING ADMINISTRATION	24,225	202,660				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,000			14.00
15.00	01500	PHARMACY	53,574	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,561	0	0	0	936,779,970	16.00
17.00	01700	SOCIAL SERVICE	6,259	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICES	20,257	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,075	111,431	0	0	18,263,446	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	88,857	39,623	0	0	93,353,375	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,840	0	0	0	30,319,902	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,702	0	0	0	62,165,159	55.00
56.00	05600	RADIOISOTOPE	12,148	0	0	0	30,318,407	56.00
57.00	05700	CT SCAN	13,885	0	0	0	68,729,416	57.00
58.00	05800	MRI	9,572	0	0	0	17,516,597	58.00
60.00	06000	LABORATORY	53,403	0	0	0	61,446,255	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	5,682,302	63.00
64.00	06400	INTRAVENOUS THERAPY	33,537	33,537	0	0	21,181,187	64.00
65.00	06500	RESPIRATORY THERAPY	22,258	0	0	0	5,302,073	65.00
66.00	06600	PHYSICAL THERAPY	22,082	0	0	0	2,848,780	66.00
69.00	06900	ELECTROCARDIOLOGY	5,422	0	0	0	3,294,396	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,000	0	4,160,682	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	1,000	500,616,351	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	10,924	0	0	0	783,980	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	160,218	0	0	0	8,479,204	90.00
91.00	09100	EMERGENCY	18,069	18,069	0	0	2,318,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	753,868	202,660	1,000	1,000	936,779,970	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE EXPENSES	85,438	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,174,194	2,670,283	1,929,528	5,601,974	2,189,952	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.973388	13.176172	1,929.528000	5,601.974000	0.002338	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	984,221	134,963	597,866	676,323	294,604	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.172661	0.665958	597.866000	676.323000	0.000314	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE S (GROSS CHARGES)		
	GENERAL SERVICE COST CENTERS	17.00	18.00		
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	936,779,970			17.00
18.00	01850 OTHER GENERAL SERVICES	0	936,779,970		18.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	18,263,446	18,263,446		30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	93,353,375	93,353,375		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	30,319,902	30,319,902		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	62,165,159	62,165,159		55.00
56.00	05600 RADIOISOTOPE	30,318,407	30,318,407		56.00
57.00	05700 CT SCAN	68,729,416	68,729,416		57.00
58.00	05800 MRI	17,516,597	17,516,597		58.00
60.00	06000 LABORATORY	61,446,255	61,446,255		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5,682,302	5,682,302		63.00
64.00	06400 INTRAVENOUS THERAPY	21,181,187	21,181,187		64.00
65.00	06500 RESPIRATORY THERAPY	5,302,073	5,302,073		65.00
66.00	06600 PHYSICAL THERAPY	2,848,780	2,848,780		66.00
69.00	06900 ELECTROCARDIOLOGY	3,294,396	3,294,396		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,160,682	4,160,682		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	500,616,351	500,616,351		73.00
76.00	03950 OTHER ANCILLARY EXPENSE	0	0		76.00
76.01	03951 HOSPITAL NUTRITION	783,980	783,980		76.01
76.02	03952 PAIN MANAGEMENT	0	0		76.02
76.03	03954 INFUSION CENTER	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	8,479,204	8,479,204		90.00
91.00	09100 EMERGENCY	2,318,458	2,318,458		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	936,779,970	936,779,970		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100 RESEARCH	0	0		191.00
194.00	07950 OTHER NONREIMBURSABLE EXPENSES	0	0		194.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	521,141	1,758,610		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000556	0.001877		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,040	170,694		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000083	0.000182		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:15 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	16,565,023		16,565,023			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,913,838	58,439,537	93,353,375	0.222546	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,790,011	26,529,891	30,319,902	0.240609	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,923,621	60,241,538	62,165,159	0.166724	0.000000	55.00
56.00	05600	RADIOISOTOPE	233,943	30,084,464	30,318,407	0.217372	0.000000	56.00
57.00	05700	CT SCAN	2,368,497	66,360,919	68,729,416	0.028681	0.000000	57.00
58.00	05800	MRI	795,333	16,721,264	17,516,597	0.086075	0.000000	58.00
60.00	06000	LABORATORY	9,688,244	51,758,011	61,446,255	0.143582	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,319,032	2,363,270	5,682,302	0.264312	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	66,169	21,115,018	21,181,187	0.218354	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,048,937	3,253,136	5,302,073	0.392196	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,241,862	1,606,918	2,848,780	0.762888	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	440,354	2,854,042	3,294,396	0.198537	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,337,076	1,823,606	4,160,682	0.468524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,349,770	468,266,581	500,616,351	0.190464	0.000000	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	130,750	653,230	783,980	1.012889	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	96,892	8,382,312	8,479,204	1.715786	0.000000	90.00
91.00	09100	EMERGENCY	820,204	1,498,254	2,318,458	0.884834	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	349,544	1,348,879	1,698,423	1.216133	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	113,479,100	823,300,870	936,779,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	113,479,100	823,300,870	936,779,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.222546			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240609			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166724			55.00
56.00	05600	RADIOISOTOPE	0.217372			56.00
57.00	05700	CT SCAN	0.028681			57.00
58.00	05800	MRI	0.086075			58.00
60.00	06000	LABORATORY	0.143582			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.264312			63.00
64.00	06400	INTRAVENOUS THERAPY	0.218354			64.00
65.00	06500	RESPIRATORY THERAPY	0.392196			65.00
66.00	06600	PHYSICAL THERAPY	0.762888			66.00
69.00	06900	ELECTROCARDIOLOGY	0.198537			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468524			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464			73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000			76.00
76.01	03951	HOSPITAL NUTRITION	1.012889			76.01
76.02	03952	PAIN MANAGEMENT	0.000000			76.02
76.03	03954	INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.715786			90.00
91.00	09100	EMERGENCY	0.884834			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.216133			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XIX		Hospital		Cost	
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	17,160,101		17,160,101	0	17,160,101	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,775,458		20,775,458	0	20,775,458	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,295,229		7,295,229	0	7,295,229	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,364,397		10,364,397	0	10,364,397	55.00
56.00	05600	RADIOISOTOPE	6,590,385		6,590,385	0	6,590,385	56.00
57.00	05700	CT SCAN	1,971,237		1,971,237	0	1,971,237	57.00
58.00	05800	MRI	1,507,738		1,507,738	0	1,507,738	58.00
60.00	06000	LABORATORY	8,822,570		8,822,570	0	8,822,570	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,501,902		1,501,902	0	1,501,902	63.00
64.00	06400	INTRAVENOUS THERAPY	4,624,999		4,624,999	0	4,624,999	64.00
65.00	06500	RESPIRATORY THERAPY	2,079,452	0	2,079,452	0	2,079,452	65.00
66.00	06600	PHYSICAL THERAPY	2,173,301	0	2,173,301	0	2,173,301	66.00
69.00	06900	ELECTROCARDIOLOGY	654,058		654,058	0	654,058	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,949,379		1,949,379	0	1,949,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,349,197		95,349,197	0	95,349,197	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	794,085		794,085	0	794,085	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14,548,501		14,548,501	0	14,548,501	90.00
91.00	09100	EMERGENCY	2,051,451		2,051,451	0	2,051,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,065,509		2,065,509		2,065,509	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	202,278,949	0	202,278,949	0	202,278,949	200.00
201.00		Less Observation Beds	2,065,509		2,065,509		2,065,509	201.00
202.00		Total (see instructions)	200,213,440	0	200,213,440	0	200,213,440	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,565,023		16,565,023			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,913,838	58,439,537	93,353,375	0.222546	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,790,011	26,529,891	30,319,902	0.240609	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,923,621	60,241,538	62,165,159	0.166724	0.000000	55.00
56.00	05600	RADIOISOTOPE	233,943	30,084,464	30,318,407	0.217372	0.000000	56.00
57.00	05700	CT SCAN	2,368,497	66,360,919	68,729,416	0.028681	0.000000	57.00
58.00	05800	MRI	795,333	16,721,264	17,516,597	0.086075	0.000000	58.00
60.00	06000	LABORATORY	9,688,244	51,758,011	61,446,255	0.143582	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,319,032	2,363,270	5,682,302	0.264312	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	66,169	21,115,018	21,181,187	0.218354	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,048,937	3,253,136	5,302,073	0.392196	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,241,862	1,606,918	2,848,780	0.762888	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	440,354	2,854,042	3,294,396	0.198537	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,337,076	1,823,606	4,160,682	0.468524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,349,770	468,266,581	500,616,351	0.190464	0.000000	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	130,750	653,230	783,980	1.012889	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	96,892	8,382,312	8,479,204	1.715786	0.000000	90.00
91.00	09100	EMERGENCY	820,204	1,498,254	2,318,458	0.884834	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	349,544	1,348,879	1,698,423	1.216133	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	113,479,100	823,300,870	936,779,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	113,479,100	823,300,870	936,779,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000			76.00
76.01	03951	HOSPITAL NUTRITION	0.000000			76.01
76.02	03952	PAIN MANAGEMENT	0.000000			76.02
76.03	03954	INFUSION CENTER	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 3:15 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	4,952,211	0	4,952,211	5,342	927.03	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
200.00	Total (lines 30 through 199)	4,952,211		4,952,211	5,342		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,393	1,291,353				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
200.00	Total (lines 30 through 199)	1,393	1,291,353				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XVIII		Hospital	PPS		
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,779,421	93,353,375	0.040485	6,441,020	260,765	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,034,464	30,319,902	0.034118	1,138,320	38,837	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,698,875	62,165,159	0.043415	963,841	41,845	55.00
56.00	05600	RADIOISOTOPE	182,740	30,318,407	0.006027	66,136	399	56.00
57.00	05700	CT SCAN	146,924	68,729,416	0.002138	847,851	1,813	57.00
58.00	05800	MRI	138,214	17,516,597	0.007890	308,640	2,435	58.00
60.00	06000	LABORATORY	996,691	61,446,255	0.016221	3,051,775	49,503	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	101,082	5,682,302	0.017789	1,176,059	20,921	63.00
64.00	06400	INTRAVENOUS THERAPY	827,092	21,181,187	0.039048	15,124	591	64.00
65.00	06500	RESPIRATORY THERAPY	93,288	5,302,073	0.017595	732,138	12,882	65.00
66.00	06600	PHYSICAL THERAPY	385,252	2,848,780	0.135234	447,364	60,499	66.00
69.00	06900	ELECTROCARDIOLOGY	56,436	3,294,396	0.017131	200,143	3,429	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	600,274	4,160,682	0.144273	695,570	100,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,686,675	500,616,351	0.005367	8,545,903	45,866	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	69,345	783,980	0.088453	40,575	3,589	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,821,029	8,479,204	0.332700	29,583	9,842	90.00
91.00	09100	EMERGENCY	224,749	2,318,458	0.096939	286,863	27,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	596,083	1,698,423	0.350963	0	0	92.00
200.00	Total (lines 50 through 199)		17,438,634	920,214,947		24,986,905	681,376	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0100		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 3:15 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	0	0	0	0	0	34.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	5,342	0.00	1,393		30.00
31.00	03100	INTENSIVE CARE UNIT			0	0	0.00	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			0	0	0.00	0		34.00
200.00		Total (lines 30 through 199)			0	5,342		1,393		200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0						34.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	93,353,375	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,319,902	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	62,165,159	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	30,318,407	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	68,729,416	0.000000	57.00
58.00	05800	MRI	0	0	0	17,516,597	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	61,446,255	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,682,302	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	21,181,187	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,302,073	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,848,780	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,294,396	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,160,682	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	500,616,351	0.000000	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0	0	0	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	783,980	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	8,479,204	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	2,318,458	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,698,423	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	920,214,947		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 3:15 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,441,020	0	14,167,010	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,138,320	0	6,577,128	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	963,841	0	19,912,473	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	66,136	0	8,587,399	0	56.00	
57.00	05700	CT SCAN	0.000000	847,851	0	20,000,486	0	57.00	
58.00	05800	MRI	0.000000	308,640	0	4,330,190	0	58.00	
60.00	06000	LABORATORY	0.000000	3,051,775	0	12,857,156	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	1,176,059	0	621,188	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	15,124	0	5,768,173	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	732,138	0	1,006,637	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	447,364	0	111,397	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	200,143	0	621,524	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	695,570	0	398,798	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,545,903	0	140,959,430	0	73.00	
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	0	0	0	76.00	
76.01	03951	HOSPITAL NUTRITION	0.000000	40,575	0	0	0	76.01	
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02	
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	29,583	0	2,540,879	0	90.00	
91.00	09100	EMERGENCY	0.000000	286,863	0	309,054	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	1,300	0	92.00	
200.00		Total (lines 50 through 199)		24,986,905	0	238,770,222	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.222546	14,167,010	0	0	3,152,811	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240609	6,577,128	0	360	1,582,516	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166724	19,912,473	0	0	3,319,887	55.00
56.00	05600	RADIOISOTOPE	0.217372	8,587,399	0	144	1,866,660	56.00
57.00	05700	CT SCAN	0.028681	20,000,486	0	6,765	573,634	57.00
58.00	05800	MRI	0.086075	4,330,190	0	2,087	372,721	58.00
60.00	06000	LABORATORY	0.143582	12,857,156	12,812	0	1,846,056	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.264312	621,188	3	0	164,187	63.00
64.00	06400	INTRAVENOUS THERAPY	0.218354	5,768,173	0	96	1,259,504	64.00
65.00	06500	RESPIRATORY THERAPY	0.392196	1,006,637	0	0	394,799	65.00
66.00	06600	PHYSICAL THERAPY	0.762888	111,397	0	0	84,983	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198537	621,524	0	72	123,396	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468524	398,798	0	0	186,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464	140,959,430	0	710,299	26,847,697	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.012889	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.715786	2,540,879	0	2,646	4,359,605	90.00
91.00	09100	EMERGENCY	0.884834	309,054	0	1	273,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.216133	1,300	0	0	1,581	92.00
200.00		Subtotal (see instructions)		238,770,222	12,815	722,470	46,410,344	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		238,770,222	12,815	722,470	46,410,344	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	31		56.00
57.00	05700	CT SCAN	0	194		57.00
58.00	05800	MRI	0	180		58.00
60.00	06000	LABORATORY	1,840	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	21		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	14		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	135,286		73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	4,540		90.00
91.00	09100	EMERGENCY	0	1		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	1,841	140,354		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,841	140,354		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XIX		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.222546	117,375	0	0	26,121	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240609	106,657	0	0	25,663	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166724	312,955	0	0	52,177	55.00
56.00	05600	RADIOISOTOPE	0.217372	4,368	0	0	949	56.00
57.00	05700	CT SCAN	0.028681	142,956	0	0	4,100	57.00
58.00	05800	MRI	0.086075	60,234	0	0	5,185	58.00
60.00	06000	LABORATORY	0.143582	121,763	0	0	17,483	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.264312	1,779	0	0	470	63.00
64.00	06400	INTRAVENOUS THERAPY	0.218354	26,591	0	0	5,806	64.00
65.00	06500	RESPIRATORY THERAPY	0.392196	4,244	0	0	1,664	65.00
66.00	06600	PHYSICAL THERAPY	0.762888	9,446	0	0	7,206	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198537	21,350	0	0	4,239	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468524	106,340	0	0	49,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464	1,056,689	0	0	201,261	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.012889	594	0	0	602	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1.715786	13,019	0	0	22,338	90.00
91.00	09100	EMERGENCY	0.884834	59,840	0	0	52,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.216133	5,161	0	0	6,276	92.00
200.00		Subtotal (see instructions)		2,171,361	0	0	484,311	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		2,171,361	0	0	484,311	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 3:15 pm

			Title XIX		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 3:15 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,342	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,342	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,699	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,393	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,160,101	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		17,160,101	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,160,101	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		3,212.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,474,734	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,474,734	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:15 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,653,023 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,127,757 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,291,353 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					681,376 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,972,729 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,155,028 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					643 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,212.30 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,065,509 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	4,952,211	17,160,101	0.288589	2,065,509	596,083
91.00	Nursing School cost	0	17,160,101	0.000000	2,065,509	0
92.00	Allied health cost	0	17,160,101	0.000000	2,065,509	0
93.00	All other Medical Education	0	17,160,101	0.000000	2,065,509	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 3:15 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,342 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,342 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4,699 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			17,160,101 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			17,160,101 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			17,160,101 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			3,212.30 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			9,637 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			9,637 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,442	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,079	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					643	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,212.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,065,509	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,952,211	17,160,101	0.288589	2,065,509	596,083	90.00
91.00	Nursing School cost	0	17,160,101	0.000000	2,065,509	0	91.00
92.00	Allied health cost	0	17,160,101	0.000000	2,065,509	0	92.00
93.00	All other Medical Education	0	17,160,101	0.000000	2,065,509	0	93.00

Health Financial Systems		MIDWESTERN REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 3:15 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,948,646	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.222546	6,441,020	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240609	1,138,320	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166724	963,841	55.00
56.00	05600	RADIOISOTOPE	0.217372	66,136	56.00
57.00	05700	CT SCAN	0.028681	847,851	57.00
58.00	05800	MRI	0.086075	308,640	58.00
60.00	06000	LABORATORY	0.143582	3,051,775	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.264312	1,176,059	63.00
64.00	06400	INTRAVENOUS THERAPY	0.218354	15,124	64.00
65.00	06500	RESPIRATORY THERAPY	0.392196	732,138	65.00
66.00	06600	PHYSICAL THERAPY	0.762888	447,364	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198537	200,143	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468524	695,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464	8,545,903	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.012889	40,575	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.715786	29,583	90.00
91.00	09100	EMERGENCY	0.884834	286,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.216133	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		24,986,905	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		24,986,905	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 3:15 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,215	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.222546	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.240609	543	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.166724	0	55.00
56.00	05600	RADIOISOTOPE	0.217372	0	56.00
57.00	05700	CT SCAN	0.028681	6,435	57.00
58.00	05800	MRI	0.086075	0	58.00
60.00	06000	LABORATORY	0.143582	10,078	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.264312	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.218354	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.392196	0	65.00
66.00	06600	PHYSICAL THERAPY	0.762888	620	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198537	916	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.468524	1,469	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.190464	11,786	73.00
76.00	03950	OTHER ANCILLARY EXPENSE	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.012889	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.715786	0	90.00
91.00	09100	EMERGENCY	0.884834	2,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.216133	1,770	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,807	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		35,807	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 3:15 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)			771,413	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,074,682	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)			344,124	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			1,304,335	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)			71.24	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)		or	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)			0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)			0.00	31.00
32.00	Sum of lines 30 and 31			0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)			0.00	33.00
34.00	Disproportionate share adjustment (see instructions)			0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 3:15 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	4,494,554			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)			4,494,554	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			634,100	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			24,058	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)			5,152,712	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,152,712	61.00
62.00	Deductibles billed to program beneficiaries			210,660	62.00
63.00	Coinsurance billed to program beneficiaries			371	63.00
64.00	Allowable bad debts (see instructions)			12,322	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			8,009	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,949,690	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			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)			22,174	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
11/29/2021 3:15 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	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	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			51,749	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			4,920,115	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			4,926,617	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)			-6,502	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	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	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	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 3:15 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	771,413	0	771,413		771,413
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,074,682	0		2,074,682	2,074,682
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	344,124	0	344,124		344,124
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,304,335	0		1,304,335	1,304,335
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	4,494,554	0	1,115,537	3,379,017	4,494,554
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,494,554	0	1,115,537	3,379,017	4,494,554
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	634,100	0	148,937	485,163	634,100
17.00	Special add-on payments for new technologies	54.00	24,058	0	0	24,058	24,058
17.01	Net organ acquisition cost						

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 3:15 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,264,474	3,888,238	5,152,712
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	222,716	0	61,522	161,194	222,716
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	411,384	0	87,415	323,969	411,384
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	634,100	0	148,937	485,163	634,100
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 3:15 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	771,413	771,413		771,413	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,074,682		2,074,682	2,074,682	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	344,124	344,124		344,124	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,304,335		1,304,335	1,304,335	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,494,554	1,115,537	3,379,017	4,494,554	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,494,554	1,115,537	3,379,017	4,494,554	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	634,100	148,937	485,163	634,100	16.00
17.00	Special add-on payments for new technologies	54.00	24,058	0	24,058	24,058	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,264,474	3,888,238	5,152,712	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 3:15 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	222,716	61,522	161,194	222,716	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	411,384	87,415	323,969	411,384	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	634,100	148,937	485,163	634,100	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	22,174	5,804	16,370	22,174	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		12,703	39,046	51,749	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 3:15 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		142,195	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		46,410,344	2.00
3.00	OPPS payments		28,987,104	3.00
4.00	Outlier payment (see instructions)		2,082,548	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)		142,195	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		735,285	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)		735,285	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)		735,285	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		593,090	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)		142,195	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)		31,069,652	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)		3,981,984	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)		27,229,863	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)		27,229,863	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		27,229,863	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)		258,492	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		168,020	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		27,397,883	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)		27,397,883	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		27,431,108	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)		-33,225	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 3:15 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		4,912,106		27,101,670	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		21,403		378,409	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	02/16/2021	6,892	02/16/2021	48,971	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)		-6,892		-48,971	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)		4,926,617		27,431,108	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		6,502		33,225	6.02	
7.00	Total Medicare program liability (see instructions)		4,920,115		27,397,883	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/29/2021 3:15 pm

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

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

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/29/2021 3:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	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)	0	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	0				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/29/2021 3:15 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		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-277,711,904				2.00
3.00	Total (sum of line 1 and line 2)		-277,711,904		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-277,711,904		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)		-277,711,904		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	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: 14-0100

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 3:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF				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)	0		0	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	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)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		277,711,904		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)		277,711,904		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0100

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/29/2021 3:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	277,711,904	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-277,711,904	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-277,711,904	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)	-277,711,904	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0100	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/29/2021 3:15 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		222,716	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		411,384	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)		12.87	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		634,100	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