

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: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 7/29/2022 2:22 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/29/2022	Time: 2:22 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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. BERNARD HOSPITAL (14-0103) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	132,837	-101,829	0	0	1.00
2.00 Subprovider - IPF	0	15,133	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	147,970	-101,829	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: 14-0103		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/29/2022 2:22 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 326 W 64TH STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60621		County: COOK	
		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			ST. BERNARD HOSPITAL	140103	16984	1	07/01/1967	N
4.00	Subprovider - IPF			ST. BERNARD HOSPITAL	14S103	16984	4	01/01/1994	N
5.00	Subprovider - IRF			PSYCH UNIT					P
6.00	Subprovider - (Other)								P
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)						01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

Worksheet S-2
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

MCRIF32 - 17.8.174.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0103		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/29/2022 2:22 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 7/29/2022 2:22 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.		N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	246,306	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/29/2022 2:22 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:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
						1.00	
						2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				N	0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/29/2022 2:22 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		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.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/06/2022	Y 07/06/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/29/2022 2:22 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.	CONSULTANT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/29/2022 2:22 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	104	37,960	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)		104	37,960	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		114	41,610	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	60	21,900		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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)		174			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: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/29/2022 2:22 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)	2,841	925	12,041			1.00
2.00	HMO and other (see instructions)	2,896	6,992				2.00
3.00	HMO IPF Subprovider	245	5,425				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)	2,841	925	12,041			7.00
8.00	INTENSIVE CARE UNIT	544	425	3,874			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	3,385	1,350	15,915	4.00	576.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	872	318	7,770	0.00	60.99	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)				4.00	637.02	27.00
28.00	Observation Bed Days		0	2,117			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: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/29/2022 2:22 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	512	187	2,473	1.00
2.00 HMO and other (see instructions)			404	1,182		2.00
3.00 HMO IPF Subprovider				1,118		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	512	187	2,473	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	164	70	1,591	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: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/29/2022 2:22 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	42,245,865	0	42,245,865	1,331,921.00	31.72
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)		558,689	0	558,689	8,320.00	67.15
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)		4,048,128	667,690	4,715,818	155,511.00	30.32
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		9,368,360	0	9,368,360	102,117.00	91.74
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		101,345	0	101,345	675.00	150.14
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,523,838	0	10,523,838		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,360,859	0	1,360,859		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	283,767	0	283,767	9,194.00	30.86	26.00
27.00	Administrative & General	5.00	5,666,935	0	5,666,935	168,709.00	33.59	27.00
28.00	Administrative & General under contract (see inst.)		405,990	0	405,990	5,522.00	73.52	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,571,060	0	2,571,060	93,808.00	27.41	30.00
31.00	Laundry & Linen Service	8.00	116,241	0	116,241	6,198.00	18.75	31.00
32.00	Housekeeping	9.00	1,747,711	0	1,747,711	94,723.00	18.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	939,077	-422,658	516,419	28,294.00	18.25	34.00
35.00	Dietary under contract (see instructions)		441,766	0	441,766	4,839.00	91.29	35.00
36.00	Cafeteria	11.00	0	422,658	422,658	22,104.00	19.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	977,908	0	977,908	28,683.00	34.09	38.00
39.00	Central Services and Supply	14.00	448,227	0	448,227	21,362.00	20.98	39.00
40.00	Pharmacy	15.00	1,718,321	0	1,718,321	44,762.00	38.39	40.00
41.00	Medical Records & Medical Records Library	16.00	612,960	0	612,960	26,312.00	23.30	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
7/29/2022 2:22 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)	42,534,932	0	42,534,932	1,333,962.00	31.89	1.00
2.00	Excluded area salaries (see instructions)	4,048,128	667,690	4,715,818	155,511.00	30.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	38,486,804	-667,690	37,819,114	1,178,451.00	32.09	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,469,705	0	9,469,705	102,792.00	92.12	4.00
5.00	Subtotal wage-related costs (see inst.)	10,523,838	0	10,523,838	0.00	27.83	5.00
6.00	Total (sum of lines 3 thru 5)	58,480,347	-667,690	57,812,657	1,281,243.00	45.12	6.00
7.00	Total overhead cost (see instructions)	15,929,963	0	15,929,963	554,510.00	28.73	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	450,833	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)	7,717,822	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67,744	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	101,204	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	418,895	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	3,102,545	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	23,404	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	2,250	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,884,697	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	9,368,360	11,884,697	1.00
2.00	Hospital	9,368,360	10,523,838	2.00
3.00	SUBPROVIDER - IPF	0	1,117,900	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	242,959	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 7/29/2022 2:22 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)			0.538081 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	25,400,870		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	92,752,263		6.00
7.00	Medicaid cost (line 1 times line 6)	49,908,230		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)	24,507,360		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)	24,507,360		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)	6,251,818	1,214,846	7,466,664 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,363,984	1,214,846	4,578,830 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)	3,363,984	1,214,846	4,578,830 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)	617,645		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	221,505		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	340,778		27.01
28.00	Non-Medicare bad debt expense (see instructions)	276,867		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	268,250		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,847,080		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	29,354,440		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0103

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

Worksheet A

Date/Time Prepared:
7/29/2022 2:22 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		4,638,156	4,638,156	-1,578,927	3,059,229	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,996,144	1,996,144	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	283,767	9,052,654	9,336,421	0	9,336,421	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,666,935	11,079,524	16,746,459	-81,531	16,664,928	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,571,060	3,401,011	5,972,071	-393,056	5,579,015	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	116,241	287,930	404,171	0	404,171	8.00
9.00	00900	HOUSEKEEPING	1,747,711	479,062	2,226,773	0	2,226,773	9.00
10.00	01000	DIETARY	939,077	1,749,789	2,688,866	-1,210,199	1,478,667	10.00
11.00	01100	CAFETERIA	0	0	0	1,210,199	1,210,199	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	977,908	171,382	1,149,290	0	1,149,290	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	448,227	857,043	1,305,270	-214,533	1,090,737	14.00
15.00	01500	PHARMACY	1,718,321	1,701,272	3,419,593	-1,498,874	1,920,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	612,960	356,736	969,696	0	969,696	16.00
17.00	01700	SOCIAL SERVICE	0	2,241,489	2,241,489	0	2,241,489	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	558,689	558,689	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,688,395	7,658,434	13,346,829	-2,494,570	10,852,259	30.00
31.00	03100	INTENSIVE CARE UNIT	2,263,362	1,474,945	3,738,307	-300,205	3,438,102	31.00
40.00	04000	SUBPROVIDER - IPF	3,232,574	1,042,391	4,274,965	588,017	4,862,982	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,359,163	1,162,164	2,521,327	-677,920	1,843,407	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	36,599	2,178,794	2,215,393	-73,478	2,141,915	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,621,705	2,755,550	5,377,255	-95,052	5,282,203	54.00
60.00	06000	LABORATORY	2,273,056	2,969,592	5,242,648	-70,466	5,172,182	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	922,523	738,646	1,661,169	-199,024	1,462,145	65.00
66.00	06600	PHYSICAL THERAPY	525,355	149,581	674,936	-4,215	670,721	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,114,914	4,114,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	237,656	237,656	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,972,268	1,972,268	73.00
74.00	07400	RENAL DIALYSIS	0	766,901	766,901	-462	766,439	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,300,185	2,845,499	5,145,684	268,437	5,414,121	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	263,851	24,089	287,940	-148,030	139,910	90.01
91.00	09100	EMERGENCY	4,861,336	5,907,679	10,769,015	-1,583,779	9,185,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		24,161	24,161	-24,161	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,430,311	65,714,474	107,144,785	297,842	107,442,627	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	283,298	156,301	439,599	0	439,599	192.00
192.01	19201	ADULT MOBILE UNIT	12,842	44,541	57,383	0	57,383	192.01
194.00	07950	OUTPATIENT PHARMACY	422,212	1,281,900	1,704,112	-379,373	1,324,739	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	81,531	81,531	194.01
194.02	07952	FUNDRAISING	97,202	10,204	107,406	0	107,406	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	42,245,865	67,207,420	109,453,285	0	109,453,285	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0103

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

Worksheet A

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-48,592	3,010,637	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-20,106	1,976,038	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-177,422	9,158,999	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-900,535	15,764,393	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-125,200	5,453,815	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	404,171	8.00
9.00	00900	HOUSEKEEPING	-50,102	2,176,671	9.00
10.00	01000	DIETARY	0	1,478,667	10.00
11.00	01100	CAFETERIA	-433,471	776,728	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-81,443	1,067,847	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,090,737	14.00
15.00	01500	PHARMACY	0	1,920,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,409	949,287	16.00
17.00	01700	SOCIAL SERVICE	0	2,241,489	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	558,689	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,929,423	8,922,836	30.00
31.00	03100	INTENSIVE CARE UNIT	-12,000	3,426,102	31.00
40.00	04000	SUBPROVIDER - IPF	-776,157	4,086,825	40.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,004	1,840,403	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-2,072,920	68,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,105,973	4,176,230	54.00
60.00	06000	LABORATORY	0	5,172,182	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-24,000	1,438,145	65.00
66.00	06600	PHYSICAL THERAPY	0	670,721	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,114,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	237,656	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,972,268	73.00
74.00	07400	RENAL DIALYSIS	0	766,439	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-3,304,496	2,109,625	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	-2,590	137,320	90.01
91.00	09100	EMERGENCY	-3,504,514	5,680,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,592,357	92,850,270	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	439,599	192.00
192.01	19201	ADULT MOBILE UNIT	0	57,383	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,324,739	194.00
194.01	07951	PUBLIC RELATIONS	0	81,531	194.01
194.02	07952	FUNDRAISING	0	107,406	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-14,592,357	94,860,928	200.00

RECLASSIFICATIONS

Provider CCN: 14-0103

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

Worksheet A-6

Date/Time Prepared:
7/29/2022 2:22 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - RECLASSIFY INTERNS & RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	558,689		1.00
	TOTALS		0	558,689		
	C - RECLASSIFY MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,352,570		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	4,352,570		
	D - RECLASSIFY DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,972,268		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
	TOTALS		0	1,972,268		
	G - RECLASSIFY EMERGENCY ROOM					
1.00	SUBPROVIDER - IPF	40.00	519,945	39,776		1.00
	TOTALS		519,945	39,776		
	H - RECLASSIFY DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,971,983		1.00
	TOTALS		0	1,971,983		
	I - RECLASSIFY PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	393,056		1.00
	TOTALS		0	393,056		
	J - RECLASSIFY INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	24,161		1.00
	TOTALS		0	24,161		
	L - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	422,658	787,541		1.00
	TOTALS		422,658	787,541		
	P - RECLASS PR COSTS					
1.00	PUBLIC RELATIONS	194.01	0	81,531		1.00
	TOTALS		0	81,531		
	Q - RECLASS IMPLANT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	237,656		1.00
	TOTALS		0	237,656		
	R - OP BEHAVIORAL HEALTH					
1.00	CLINIC	90.00	0	119,369		1.00
	TOTALS		0	119,369		
	S - 340B DRUGS RECLASS					
1.00	CLINIC	90.00	0	379,373		1.00
	TOTALS		0	379,373		
	T - PHP RELCASS					
1.00	SUBPROVIDER - IPF	40.00	147,745	0		1.00
	TOTALS		147,745	0		
500.00	Grand Total: Increases		1,090,348	10,917,973		500.00

RECLASSIFICATIONS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet A-6
Date/Time Prepared:
7/29/2022 2:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - RECLASSIFY INTERNS & RESIDENTS						
1.00	EMERGENCY	91.00	0	558,689	0		1.00
	TOTALS		0	558,689			
	C - RECLASSIFY MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,035,749	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	300,026	0		2.00
3.00	OPERATING ROOM	50.00	0	677,890	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	499	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	73,478	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	91,104	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,887	0		7.00
8.00	LABORATORY	60.00	0	70,466	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	199,024	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	4,215	0		10.00
11.00	RENAL DIALYSIS	74.00	0	462	0		11.00
12.00	CLINIC	90.00	0	216,119	0		12.00
13.00	PARTIAL HOSPITALIZATION PROGRAM	90.01	0	285	0		13.00
14.00	EMERGENCY	91.00	0	464,833	0		14.00
15.00	CENTRAL SERVICES & SUPPLY	14.00	0	214,533	0		15.00
	TOTALS		0	4,352,570			
	D - RECLASSIFY DRUGS SOLD						
1.00	PHARMACY	15.00	0	1,498,874	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	458,322	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	179	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	80	0		4.00
5.00	OPERATING ROOM	50.00	0	30	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	61	0		6.00
7.00	CLINIC	90.00	0	14,186	0		7.00
8.00	EMERGENCY	91.00	0	536	0		8.00
10.00	RADIOLOGY-DIAGNOSTIC		0		0		10.00
11.00	LABORATORY		0		0		11.00
13.00	CLINIC		0		0		13.00
15.00	EMERGENCY		0		0		15.00
	TOTALS		0	1,972,268			
	G - RECLASSIFY EMERGENCY ROOM						
1.00	EMERGENCY	91.00	519,945	39,776	0		1.00
	TOTALS		519,945	39,776			
	H - RECLASSIFY DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,971,983	9		1.00
	TOTALS		0	1,971,983			
	I - RECLASSIFY PROPERTY INSURANCE						
1.00	OPERATION OF PLANT	7.00	0	393,056	12		1.00
	TOTALS		0	393,056			
	J - RECLASSIFY INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	24,161	11		1.00
	TOTALS		0	24,161			
	L - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	422,658	787,541	0		1.00
	TOTALS		422,658	787,541			
	P - RECLASS PR COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,531	0		1.00
	TOTALS		0	81,531			
	Q - RECLASS IMPLANT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	237,656	0		1.00
	TOTALS		0	237,656			
	R - OP BEHAVIORAL HEALTH						
1.00	SUBPROVIDER - IPF	40.00	0	119,369	0		1.00
	TOTALS		0	119,369			
	S - 340B DRUGS RECLASS						
1.00	OUTPATIENT PHARMACY	194.00	0	379,373	0		1.00
	TOTALS		0	379,373			
	T - PHP RELCASS						
1.00	PARTIAL HOSPITALIZATION PROGRAM	90.01	147,745	0	0		1.00
	TOTALS		147,745	0			
500.00	Grand Total: Decreases		1,090,348	10,917,973			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,192,754	0	0	0	0	1.00
2.00	Land Improvements	4,683,791	0	0	0	0	2.00
3.00	Buildings and Fixtures	89,438,250	1,876,216	0	1,876,216	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	58,921,022	1,229,771	0	1,229,771	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	155,235,817	3,105,987	0	3,105,987	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	155,235,817	3,105,987	0	3,105,987	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,192,754	0	1.00			
2.00	Land Improvements	4,683,791	0	2.00			
3.00	Buildings and Fixtures	91,314,466	0	3.00			
4.00	Building Improvements	0	0	4.00			
5.00	Fixed Equipment	0	0	5.00			
6.00	Movable Equipment	60,150,793	0	6.00			
7.00	HIT designated Assets	0	0	7.00			
8.00	Subtotal (sum of lines 1-7)	158,341,804	0	8.00			
9.00	Reconciling Items	0	0	9.00			
10.00	Total (line 8 minus line 9)	158,341,804	0	10.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
7/29/2022 2:22 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	4,638,156	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,638,156	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,638,156				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,638,156				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
7/29/2022 2:22 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	98,191,011	0	98,191,011	0.620121	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	60,150,793	0	60,150,793	0.379879	0	2.00
3.00	Total (sum of lines 1-2)	158,341,804	0	158,341,804	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	2,641,742	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,951,877	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,593,619	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-24,161	393,056	0	0	3,010,637	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,161	0	0	0	1,976,038	2.00
3.00	Total (sum of lines 1-2)	0	393,056	0	0	4,986,675	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0103

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

Worksheet A-8

Date/Time Prepared:
7/29/2022 2:22 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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-24,161	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-10,293,589			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-415,299	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20,409	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-18,172	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE OFFSET	B	-47,321	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0103

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

Worksheet A-8

Date/Time Prepared:
7/29/2022 2:22 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 MIDWIFERY REVENUE	B	-171	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 OFFSET NURSE PRACTNR	A	-2,305	SUBPROVIDER - IPF	40.00	0	35.00
38.00 OFFSET NURSE PRACTNR	A	-2,565	SUBPROVIDER - IPF	40.00	0	38.00
39.00 OFFSET NURSE PRACTNR	A	-2,590	PARTIAL HOSPITALIZATION PROGRAM	90.01	0	39.00
40.00 MEDICAL GROUP REVENUE	B	-127,801	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 ER PHYSICIAN BILLING EXPENSE	A	-197,158	EMERGENCY	91.00	0	41.00
42.00 OFFSET DENTAL CLINIC COSTS	A	-1,443,988	CLINIC	90.00	0	42.00
42.01 PEDS VAN	A	-350,367	CLINIC	90.00	0	42.01
43.00 OFFSET OTHER LOBBYING COSTS	A	-144,000	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00 OFFSET SPECIAL NEEDS CLINIC	A	-433,321	CLINIC	90.00	0	45.00
45.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02 OFFSET OH RELATED TO CLINICS	A	-177,422	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03 OFFSET OH RELATED TO CLINICS	A	-556,198	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04 OFFSET OH RELATED TO CLINICS	A	-24,431	CAP REL COSTS-BLDG & FIXT	1.00	9	45.04
45.05 OFFSET OH RELATED TO CLINICS	A	-20,106	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.05
45.06 OFFSET OH RELATED TO CLINICS	A	-125,200	OPERATION OF PLANT	7.00	0	45.06
45.07 OFFSET OH RELATED TO CLINICS	A	-50,102	HOUSEKEEPING	9.00	0	45.07
45.08 OFFSET OH RELATED TO CLINICS	A	-81,443	NURSING ADMINISTRATION	13.00	0	45.08
45.09 OFFSET OB BILLING FEES	A	-9,194	ADULTS & PEDIATRICS	30.00	0	45.09
45.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
45.11 LOBBY DUES	A	-25,044	ADMINISTRATIVE & GENERAL	5.00	0	45.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,592,357				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0103

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

Worksheet A-8-2

Date/Time Prepared:
7/29/2022 2:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,920,229	1,920,229	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	12,000	12,000	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	771,287	771,287	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	3,004	3,004	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,072,920	2,072,920	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	1,105,973	1,105,973	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	24,000	24,000	0	0	0	8.00
9.00	90.00	CLINIC	1,076,820	1,076,820	0	0	0	9.00
10.00	91.00	EMERGENCY	3,307,356	3,307,356	0	0	0	10.00
200.00			10,293,589	10,293,589	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,920,229		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	12,000		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	771,287		3.00
4.00	0.00		0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	3,004		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	2,072,920		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,105,973		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	24,000		8.00
9.00	90.00	CLINIC	0	0	0	1,076,820		9.00
10.00	91.00	EMERGENCY	0	0	0	3,307,356		10.00
200.00			0	0	0	10,293,589		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/29/2022 2:22 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	3,010,637	3,010,637			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,976,038		1,976,038		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,158,999	8,057	5,288	9,172,344	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,764,393	993,819	652,298	1,238,713	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,453,815	367,858	241,444	561,998	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	404,171	15,261	10,016	25,409	8.00
9.00	00900	HOUSEKEEPING	2,176,671	34,798	22,840	382,025	9.00
10.00	01000	DIETARY	1,478,667	43,996	28,877	112,882	10.00
11.00	01100	CAFETERIA	776,728	18,732	12,295	92,387	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,067,847	31,918	20,949	213,757	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,090,737	21,464	14,088	97,976	14.00
15.00	01500	PHARMACY	1,920,719	17,926	11,766	375,601	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	949,287	20,141	13,220	133,984	16.00
17.00	01700	SOCIAL SERVICE	2,241,489	11,508	7,553	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	558,689	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,922,836	237,133	155,642	1,243,421	30.00
31.00	03100	INTENSIVE CARE UNIT	3,426,102	53,872	35,359	494,739	31.00
40.00	04000	SUBPROVIDER - IPF	4,086,825	153,451	100,718	852,543	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,840,403	105,938	69,532	297,094	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	68,995	3,746	2,459	8,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,176,230	84,453	55,431	573,068	54.00
60.00	06000	LABORATORY	5,172,182	70,126	46,027	496,858	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,438,145	55,624	36,509	201,651	65.00
66.00	06600	PHYSICAL THERAPY	670,721	43,955	28,850	114,835	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,114,914	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,656	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,972,268	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	766,439	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,109,625	101,762	66,791	502,788	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	137,320	12,770	8,381	25,379	90.01
91.00	09100	EMERGENCY	5,680,722	92,819	60,922	948,967	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)	92,850,270	2,601,127	1,707,255	8,994,075	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	439,599	400,782	263,054	61,925	192.00
192.01	19201	ADULT MOBILE UNIT	57,383	0	0	2,807	192.01
194.00	07950	OUTPATIENT PHARMACY	1,324,739	8,728	5,729	92,290	194.00
194.01	07951	PUBLIC RELATIONS	81,531	0	0	0	194.01
194.02	07952	FUNDRAISING	107,406	0	0	21,247	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	94,860,928	3,010,637	1,976,038	9,172,344	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/29/2022 2:22 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	18,649,223					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,621,186	0	8,246,301			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	111,305	0	76,691	642,853		8.00
9.00	00900	HOUSEKEEPING	640,225	0	174,875	0	3,431,434	9.00
10.00	01000	DIETARY	407,289	0	221,099	0	94,898	10.00
11.00	01100	CAFETERIA	220,267	0	94,135	0	40,404	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	326,549	0	160,401	0	68,846	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	299,581	0	107,867	0	46,298	14.00
15.00	01500	PHARMACY	569,182	0	90,086	0	38,666	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	273,243	0	101,221	0	43,445	16.00
17.00	01700	SOCIAL SERVICE	553,163	0	57,831	0	24,822	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	136,713	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,583,815	0	1,191,703	326,814	511,493	30.00
31.00	03100	INTENSIVE CARE UNIT	981,277	0	270,731	105,147	116,201	31.00
40.00	04000	SUBPROVIDER - IPF	1,270,874	0	771,165	210,892	330,993	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	565,990	0	532,386	0	228,506	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,359	0	18,827	0	8,081	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,196,398	0	424,418	0	182,165	54.00
60.00	06000	LABORATORY	1,415,654	0	352,416	0	151,261	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	423,808	0	279,537	0	119,981	65.00
66.00	06600	PHYSICAL THERAPY	210,044	0	220,897	0	94,812	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,006,932	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,155	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	482,620	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	187,550	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	680,511	0	511,400	0	219,499	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	44,989	0	64,174	0	27,544	90.01
91.00	09100	EMERGENCY	1,659,926	0	466,458	0	200,209	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)	17,947,605	0	6,188,318	642,853	2,548,124	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	285,167	0	2,014,121	0	864,484	192.00
192.01	19201	ADULT MOBILE UNIT	14,729	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	350,289	0	43,862	0	18,826	194.00
194.01	07951	PUBLIC RELATIONS	19,951	0	0	0	0	194.01
194.02	07952	FUNDRAISING	31,482	0	0	0	0	194.02
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)	18,649,223	0	8,246,301	642,853	3,431,434	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	2,387,708					10.00
11.00	01100	CAFETERIA	0	1,254,948				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	39,907	0	1,930,174		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,721	0	70,831	1,778,563	14.00
15.00	01500	PHARMACY	0	62,277	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,608	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,178,232	231,862	0	552,578	0	30.00
31.00	03100	INTENSIVE CARE UNIT	319,790	61,409	0	146,350	0	31.00
40.00	04000	SUBPROVIDER - IPF	889,686	176,500	0	420,597	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	52,698	0	125,590	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,691	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,496	0	0	0	54.00
60.00	06000	LABORATORY	0	89,711	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	47,692	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,737	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,672,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	106,292	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	79,785	0	190,117	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	8,942	0	21,310	0	90.01
91.00	09100	EMERGENCY	0	169,034	0	402,801	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)	2,387,708	1,215,070	0	1,930,174	1,778,563	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,344	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	25,640	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	2,894	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,387,708	1,254,948	0	1,930,174	1,778,563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			INTERNS & RESIDENTS					
			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SERVICES-SALAR		SERVICES-OTHER
						Y & FRINGES APPRV		PRGM COSTS APPRV
			15.00	16.00	17.00	21.00	22.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,086,223					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,571,149				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,896,366			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	695,402		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	212,182	1,472,457	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	88,578	473,740	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	94,475	950,169	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	67,859	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	21,841	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	170,798	0	0	0	54.00
60.00	06000	LABORATORY	0	392,419	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	115,369	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,614	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	43,280	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,980	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,086,223	111,343	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	30,115	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	23,359	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	367	0	0	0	90.01
91.00	09100	EMERGENCY	0	174,570	0	695,402	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)	3,086,223	1,571,149	2,896,366	695,402	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	0	194.02
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)	3,086,223	1,571,149	2,896,366	695,402	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,820,168	0	18,820,168	30.00
31.00	03100	INTENSIVE CARE UNIT	6,573,295	0	6,573,295	31.00
40.00	04000	SUBPROVIDER - IPF	10,308,888	0	10,308,888	40.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,885,996	0	3,885,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	154,999	0	154,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,969,457	0	6,969,457	54.00
60.00	06000	LABORATORY	8,186,654	0	8,186,654	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,718,316	0	2,718,316	65.00
66.00	06600	PHYSICAL THERAPY	1,420,465	0	1,420,465	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,837,397	0	6,837,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,083	0	410,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,652,454	0	5,652,454	73.00
74.00	07400	RENAL DIALYSIS	984,104	0	984,104	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,485,637	0	4,485,637	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	351,176	0	351,176	90.01
91.00	09100	EMERGENCY	10,551,830	-695,402	9,856,428	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)	88,310,919	-695,402	87,615,517	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,340,476	0	4,340,476	192.00
192.01	19201	ADULT MOBILE UNIT	74,919	0	74,919	192.01
194.00	07950	OUTPATIENT PHARMACY	1,870,103	0	1,870,103	194.00
194.01	07951	PUBLIC RELATIONS	101,482	0	101,482	194.01
194.02	07952	FUNDRAISING	163,029	0	163,029	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,860,928	-695,402	94,165,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

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	8,057	5,288	13,345	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,281	993,819	652,298	1,692,398	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	28,420	367,858	241,444	637,722	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,261	10,016	25,277	8.00
9.00	00900	HOUSEKEEPING	0	34,798	22,840	57,638	9.00
10.00	01000	DIETARY	7,239	43,996	28,877	80,112	10.00
11.00	01100	CAFETERIA	0	18,732	12,295	31,027	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,087	31,918	20,949	53,954	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	253,081	21,464	14,088	288,633	14.00
15.00	01500	PHARMACY	1,850	17,926	11,766	31,542	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,603	20,141	13,220	35,964	16.00
17.00	01700	SOCIAL SERVICE	1,301	11,508	7,553	20,362	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,439	237,133	155,642	419,214	30.00
31.00	03100	INTENSIVE CARE UNIT	1,301	53,872	35,359	90,532	31.00
40.00	04000	SUBPROVIDER - IPF	3,900	153,451	100,718	258,069	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,210	105,938	69,532	176,680	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,746	2,459	6,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,250	84,453	55,431	258,134	54.00
60.00	06000	LABORATORY	208,808	70,126	46,027	324,961	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	90,604	55,624	36,509	182,737	65.00
66.00	06600	PHYSICAL THERAPY	1,210	43,955	28,850	74,015	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,191	101,762	66,791	175,744	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	2,615	12,770	8,381	23,766	90.01
91.00	09100	EMERGENCY	3,801	92,819	60,922	157,542	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)	807,191	2,601,127	1,707,255	5,115,573	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	400,782	263,054	663,836	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	8,728	5,729	14,457	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	807,191	3,010,637	1,976,038	5,793,866	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/29/2022 2:22 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	1,694,200					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	147,276	0	785,816			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,111	0	7,308	42,733		8.00
9.00	00900	HOUSEKEEPING	58,161	0	16,664	0	133,019	9.00
10.00	01000	DIETARY	37,000	0	21,069	0	3,679	10.00
11.00	01100	CAFETERIA	20,010	0	8,970	0	1,566	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	29,665	0	15,285	0	2,669	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,215	0	10,279	0	1,795	14.00
15.00	01500	PHARMACY	51,707	0	8,585	0	1,499	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,823	0	9,646	0	1,684	16.00
17.00	01700	SOCIAL SERVICE	50,252	0	5,511	0	962	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	12,420	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	234,741	0	113,561	21,724	19,828	30.00
31.00	03100	INTENSIVE CARE UNIT	89,144	0	25,799	6,990	4,505	31.00
40.00	04000	SUBPROVIDER - IPF	115,452	0	73,487	14,019	12,831	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	51,417	0	50,733	0	8,858	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,850	0	1,794	0	313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,687	0	40,444	0	7,062	54.00
60.00	06000	LABORATORY	128,605	0	33,583	0	5,864	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	38,501	0	26,638	0	4,651	65.00
66.00	06600	PHYSICAL THERAPY	19,081	0	21,050	0	3,675	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,475	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,283	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,844	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	17,038	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	61,821	0	48,733	0	8,509	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	4,087	0	6,115	0	1,068	90.01
91.00	09100	EMERGENCY	150,796	0	44,450	0	7,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,630,462	0	589,704	42,733	98,779	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,906	0	191,932	0	33,510	192.00
192.01	19201	ADULT MOBILE UNIT	1,338	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	31,822	0	4,180	0	730	194.00
194.01	07951	PUBLIC RELATIONS	1,812	0	0	0	0	194.01
194.02	07952	FUNDRAISING	2,860	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,694,200	0	785,816	42,733	133,019	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	142,024					10.00
11.00	01100	CAFETERIA	0	61,707				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,962	0	103,846		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,461	0	3,811	333,337	14.00
15.00	01500	PHARMACY	0	3,062	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,800	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,082	11,401	0	29,728	0	30.00
31.00	03100	INTENSIVE CARE UNIT	19,022	3,020	0	7,874	0	31.00
40.00	04000	SUBPROVIDER - IPF	52,920	8,679	0	22,629	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,591	0	6,757	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	132	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,237	0	0	0	54.00
60.00	06000	LABORATORY	0	4,411	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,345	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	970	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	313,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,923	0	10,229	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	440	0	1,147	0	90.01
91.00	09100	EMERGENCY	0	8,312	0	21,671	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)	142,024	59,746	0	103,846	333,337	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	558	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,261	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	0	142	0	0	0	194.02
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)	142,024	61,707	0	103,846	333,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			15.00	16.00	17.00	21.00	22.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	96,941					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,112				16.00
17.00	01700	SOCIAL SERVICE	0	0	77,087			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	12,420		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	10,005	39,189			30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,177	12,609			31.00
40.00	04000	SUBPROVIDER - IPF	0	4,455	25,289			40.00
43.00	04300	NURSERY	0	0	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,200	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	1,030	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,054	0			54.00
60.00	06000	LABORATORY	0	18,531	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	5,440	0			65.00
66.00	06600	PHYSICAL THERAPY	0	783	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,041	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	376	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	96,941	5,250	0			73.00
74.00	07400	RENAL DIALYSIS	0	1,420	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,101	0			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	17	0			90.01
91.00	09100	EMERGENCY	0	8,232	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)	96,941	74,112	77,087	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0			192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0			194.00
194.01	07951	PUBLIC RELATIONS	0	0	0			194.01
194.02	07952	FUNDRAISING	0	0	0			194.02
200.00		Cross Foot Adjustments				12,420	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	96,941	74,112	77,087	12,420	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	971,283	0	971,283	30.00
31.00	03100	INTENSIVE CARE UNIT	264,392	0	264,392	31.00
40.00	04000	SUBPROVIDER - IPF	589,070	0	589,070	40.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	300,668	0	300,668	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,336	0	11,336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,452	0	428,452	54.00
60.00	06000	LABORATORY	516,678	0	516,678	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	260,605	0	260,605	65.00
66.00	06600	PHYSICAL THERAPY	119,741	0	119,741	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,932	0	406,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,580	0	25,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,035	0	146,035	73.00
74.00	07400	RENAL DIALYSIS	18,458	0	18,458	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	310,791	0	310,791	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	36,677	0	36,677	90.01
91.00	09100	EMERGENCY	400,145	0	400,145	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)	4,806,843	0	4,806,843	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	915,832	0	915,832	192.00
192.01	19201	ADULT MOBILE UNIT	1,342	0	1,342	192.01
194.00	07950	OUTPATIENT PHARMACY	52,584	0	52,584	194.00
194.01	07951	PUBLIC RELATIONS	1,812	0	1,812	194.01
194.02	07952	FUNDRAISING	3,033	0	3,033	194.02
200.00		Cross Foot Adjustments	12,420	0	12,420	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,793,866	0	5,793,866	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	448,423					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		448,423				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,200	1,200	41,962,098			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	148,026	148,026	5,666,935	-18,649,223	76,211,705	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,791	54,791	2,571,060	0	6,625,115	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,273	2,273	116,241	0	454,857	8.00
9.00	00900	HOUSEKEEPING	5,183	5,183	1,747,711	0	2,616,334	9.00
10.00	01000	DIETARY	6,553	6,553	516,419	0	1,664,422	10.00
11.00	01100	CAFETERIA	2,790	2,790	422,658	0	900,142	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,754	4,754	977,908	0	1,334,471	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,197	3,197	448,227	0	1,224,265	14.00
15.00	01500	PHARMACY	2,670	2,670	1,718,321	0	2,326,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,000	3,000	612,960	0	1,116,632	16.00
17.00	01700	SOCIAL SERVICE	1,714	1,714	0	0	2,260,550	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	558,689	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,320	35,320	5,688,395	0	10,559,032	30.00
31.00	03100	INTENSIVE CARE UNIT	8,024	8,024	2,263,362	0	4,010,072	31.00
40.00	04000	SUBPROVIDER - IPF	22,856	22,856	3,900,264	0	5,193,537	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,779	15,779	1,359,163	0	2,312,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	558	558	36,599	0	83,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,579	12,579	2,621,705	0	4,889,182	54.00
60.00	06000	LABORATORY	10,445	10,445	2,273,056	0	5,785,193	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	8,285	8,285	922,523	0	1,731,929	65.00
66.00	06600	PHYSICAL THERAPY	6,547	6,547	525,355	0	858,361	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,114,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	237,656	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,972,268	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	766,439	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,157	15,157	2,300,185	0	2,780,966	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	1,902	1,902	116,106	0	183,850	90.01
91.00	09100	EMERGENCY	13,825	13,825	4,341,391	0	6,783,430	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)	387,428	387,428	41,146,544	-18,649,223	73,344,485	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,695	59,695	283,298	0	1,165,360	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	12,842	0	60,190	192.01
194.00	07950	OUTPATIENT PHARMACY	1,300	1,300	422,212	0	1,431,486	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	81,531	194.01
194.02	07952	FUNDRAISING	0	0	97,202	0	128,653	194.02
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)	3,010,637	1,976,038	9,172,344		18,649,223	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.713833	4.406638	0.218586		0.244703	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,345		1,694,200	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000318		0.022230	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	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	0				6.00
7.00	00700	OPERATION OF PLANT	0	244,406			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,273	23,685		8.00
9.00	00900	HOUSEKEEPING	0	5,183	0	236,950	9.00
10.00	01000	DIETARY	0	6,553	0	6,553	72,985 10.00
11.00	01100	CAFETERIA	0	2,790	0	2,790	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	4,754	0	4,754	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,197	0	3,197	0 14.00
15.00	01500	PHARMACY	0	2,670	0	2,670	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,000	0	3,000	0 16.00
17.00	01700	SOCIAL SERVICE	0	1,714	0	1,714	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	35,320	12,041	35,320	36,015 30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,024	3,874	8,024	9,775 31.00
40.00	04000	SUBPROVIDER - IPF	0	22,856	7,770	22,856	27,195 40.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,779	0	15,779	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	558	0	558	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,579	0	12,579	0 54.00
60.00	06000	LABORATORY	0	10,445	0	10,445	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	8,285	0	8,285	0 65.00
66.00	06600	PHYSICAL THERAPY	0	6,547	0	6,547	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	15,157	0	15,157	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	1,902	0	1,902	0 90.01
91.00	09100	EMERGENCY	0	13,825	0	13,825	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)	0	183,411	23,685	175,955	72,985 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59,695	0	59,695	0 192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0 192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,300	0	1,300	0 194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0 194.01
194.02	07952	FUNDRAISING	0	0	0	0	0 194.02
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	8,246,301	642,853	3,431,434	2,387,708 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	33.740174	27.141777	14.481680	32.715051 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	785,816	42,733	133,019	142,024 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.215207	1.804222	0.561380	1.945934 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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	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						10.00
11.00	01100	CAFETERIA	43,365					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,379	0	582,127			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,027	0	21,362	4,629,225		14.00
15.00	01500	PHARMACY	2,152	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,265	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,012	0	166,654	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,122	0	44,138	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,099	0	126,849	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,821	0	37,877	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	93	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,680	0	0	0	0	54.00
60.00	06000	LABORATORY	3,100	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,648	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	682	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,352,569	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	276,656	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,757	0	57,338	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	309	0	6,427	0	0	90.01
91.00	09100	EMERGENCY	5,841	0	121,482	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)	41,987	0	582,127	4,629,225	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	392	0	0	0	0	192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	886	0	0	0	0	194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	FUNDRAISING	100	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,254,948	0	1,930,174	1,778,563	3,086,223	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.939191	0.000000	3.315727	0.384203	30,862.230000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	61,707	0	103,846	333,337	96,941	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.422968	0.000000	0.178391	0.072007	969.410000	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: 14-0103

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

Worksheet B-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
					SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00	21.00	22.00		
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	162,829,627					16.00
17.00	01700	SOCIAL SERVICE	0	23,685				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,990,024	12,041	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	9,180,060	3,874	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	9,791,147	7,770	0	0		40.00
43.00	04300	NURSERY	0	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,032,791	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	2,263,545	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,701,077	0	0	0		54.00
60.00	06000	LABORATORY	40,668,794	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	11,956,596	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,721,870	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,485,445	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	827,043	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,539,300	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	3,121,008	0	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,420,877	0	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	38,064	0	0	0		90.01
91.00	09100	EMERGENCY	18,091,986	0	100	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)	162,829,627	23,685	100	0		118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	ADULT MOBILE UNIT	0	0	0	0		192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0		194.00
194.01	07951	PUBLIC RELATIONS	0	0	0	0		194.01
194.02	07952	FUNDRAISING	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,571,149	2,896,366	695,402	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009649	122.286933	6,954.020000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,112	77,087	12,420	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000455	3.254676	124.200000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	18,820,168		18,820,168	0	18,820,168	30.00
31.00	03100	INTENSIVE CARE UNIT	6,573,295		6,573,295	0	6,573,295	31.00
40.00	04000	SUBPROVIDER - IPF	10,308,888		10,308,888	0	10,308,888	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,885,996		3,885,996	0	3,885,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	154,999		154,999	0	154,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,969,457		6,969,457	0	6,969,457	54.00
60.00	06000	LABORATORY	8,186,654		8,186,654	0	8,186,654	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,718,316	0	2,718,316	0	2,718,316	65.00
66.00	06600	PHYSICAL THERAPY	1,420,465	0	1,420,465	0	1,420,465	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,837,397		6,837,397	0	6,837,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,083		410,083	0	410,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,652,454		5,652,454	0	5,652,454	73.00
74.00	07400	RENAL DIALYSIS	984,104		984,104	0	984,104	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,485,637		4,485,637	0	4,485,637	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	351,176		351,176	0	351,176	90.01
91.00	09100	EMERGENCY	9,856,428		9,856,428	0	9,856,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,814,128		2,814,128	0	2,814,128	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,429,645	0	90,429,645	0	90,429,645	200.00
201.00		Less Observation Beds	2,814,128		2,814,128		2,814,128	201.00
202.00		Total (see instructions)	87,615,517	0	87,615,517	0	87,615,517	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/29/2022 2:22 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	18,689,329		18,689,329		30.00
31.00	03100	INTENSIVE CARE UNIT	9,180,060		9,180,060		31.00
40.00	04000	SUBPROVIDER - IPF	9,791,147		9,791,147		40.00
43.00	04300	NURSERY	0		0		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,028,908	5,003,883	7,032,791	0.552554	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	571,559	1,691,986	2,263,545	0.068476	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,503,077	12,198,000	17,701,077	0.393731	0.000000
60.00	06000	LABORATORY	17,806,359	22,862,435	40,668,794	0.201301	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	9,274,823	2,681,773	11,956,596	0.227349	0.000000
66.00	06600	PHYSICAL THERAPY	792,323	929,547	1,721,870	0.824955	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,412,369	2,073,076	4,485,445	1.524352	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	523,721	303,322	827,043	0.495842	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	9,427,945	2,111,355	11,539,300	0.489844	0.000000
74.00	07400	RENAL DIALYSIS	2,661,560	459,448	3,121,008	0.315316	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	269,415	2,151,462	2,420,877	1.852898	0.000000
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	38,064	38,064	9.225935	0.000000
91.00	09100	EMERGENCY	3,563,085	14,528,901	18,091,986	0.544795	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	123,984	3,176,711	3,300,695	0.852587	0.000000
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	92,619,664	70,209,963	162,829,627		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	92,619,664	70,209,963	162,829,627		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/29/2022 2:22 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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.552554			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.068476			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393731			54.00
60.00	06000	LABORATORY	0.201301			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.227349			65.00
66.00	06600	PHYSICAL THERAPY	0.824955			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495842			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489844			73.00
74.00	07400	RENAL DIALYSIS	0.315316			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.852898			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	9.225935			90.01
91.00	09100	EMERGENCY	0.544795			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.852587			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: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE			
						Disallowance			
			1.00	2.00	3.00	4.00		5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	18,820,168		18,820,168		0	18,820,168	30.00
31.00	03100	INTENSIVE CARE UNIT	6,573,295		6,573,295		0	6,573,295	31.00
40.00	04000	SUBPROVIDER - IPF	10,308,888		10,308,888		0	10,308,888	40.00
43.00	04300	NURSERY	0		0		0	0	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,885,996		3,885,996		0	3,885,996	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0		0	0	52.00
53.00	05300	ANESTHESIOLOGY	154,999		154,999		0	154,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,969,457		6,969,457		0	6,969,457	54.00
60.00	06000	LABORATORY	8,186,654		8,186,654		0	8,186,654	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0		0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,718,316	0	2,718,316		0	2,718,316	65.00
66.00	06600	PHYSICAL THERAPY	1,420,465	0	1,420,465		0	1,420,465	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,837,397		6,837,397		0	6,837,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,083		410,083		0	410,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,652,454		5,652,454		0	5,652,454	73.00
74.00	07400	RENAL DIALYSIS	984,104		984,104		0	984,104	74.00
76.97	07697	CARDIAC REHABILITATION	0		0		0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	4,485,637		4,485,637		0	4,485,637	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	351,176		351,176		0	351,176	90.01
91.00	09100	EMERGENCY	9,856,428		9,856,428		0	9,856,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,814,128		2,814,128			2,814,128	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	90,429,645	0	90,429,645		0	90,429,645	200.00
201.00		Less Observation Beds	2,814,128		2,814,128			2,814,128	201.00
202.00		Total (see instructions)	87,615,517	0	87,615,517		0	87,615,517	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

			Title XIX			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,689,329		18,689,329			30.00
31.00	03100	INTENSIVE CARE UNIT	9,180,060		9,180,060			31.00
40.00	04000	SUBPROVIDER - IPF	9,791,147		9,791,147			40.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,028,908	5,003,883	7,032,791	0.552554	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	571,559	1,691,986	2,263,545	0.068476	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,503,077	12,198,000	17,701,077	0.393731	0.000000	54.00
60.00	06000	LABORATORY	17,806,359	22,862,435	40,668,794	0.201301	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	9,274,823	2,681,773	11,956,596	0.227349	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	792,323	929,547	1,721,870	0.824955	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,412,369	2,073,076	4,485,445	1.524352	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	523,721	303,322	827,043	0.495842	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,427,945	2,111,355	11,539,300	0.489844	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,661,560	459,448	3,121,008	0.315316	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	269,415	2,151,462	2,420,877	1.852898	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	38,064	38,064	9.225935	0.000000	90.01
91.00	09100	EMERGENCY	3,563,085	14,528,901	18,091,986	0.544795	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	123,984	3,176,711	3,300,695	0.852587	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,619,664	70,209,963	162,829,627			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	92,619,664	70,209,963	162,829,627			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.552554			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.068476			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393731			54.00
60.00	06000	LABORATORY	0.201301			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.227349			65.00
66.00	06600	PHYSICAL THERAPY	0.824955			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495842			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489844			73.00
74.00	07400	RENAL DIALYSIS	0.315316			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.852898			90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	9.225935			90.01
91.00	09100	EMERGENCY	0.544795			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.852587			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

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

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,885,996	300,668	3,585,328	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	154,999	11,336	143,663	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,969,457	428,452	6,541,005	0	0	54.00
60.00	06000	LABORATORY	8,186,654	516,678	7,669,976	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,718,316	260,605	2,457,711	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,420,465	119,741	1,300,724	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,837,397	406,932	6,430,465	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,083	25,580	384,503	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,652,454	146,035	5,506,419	0	0	73.00
74.00	07400	RENAL DIALYSIS	984,104	18,458	965,646	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,485,637	310,791	4,174,846	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	351,176	36,677	314,499	0	0	90.01
91.00	09100	EMERGENCY	9,856,428	400,145	9,456,283	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,814,128	145,234	2,668,894	0	0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	54,727,294	3,127,332	51,599,962	0	0	200.00
201.00		Less Observation Beds	2,814,128	145,234	2,668,894	0	0	201.00
202.00		Total (line 200 minus line 201)	51,913,166	2,982,098	48,931,068	0	0	202.00

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

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

			Title XIX		Hospital	PPS
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,885,996	7,032,791	0.552554	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	154,999	2,263,545	0.068476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,969,457	17,701,077	0.393731	54.00
60.00	06000	LABORATORY	8,186,654	40,668,794	0.201301	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	2,718,316	11,956,596	0.227349	65.00
66.00	06600	PHYSICAL THERAPY	1,420,465	1,721,870	0.824955	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,837,397	4,485,445	1.524352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,083	827,043	0.495842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,652,454	11,539,300	0.489844	73.00
74.00	07400	RENAL DIALYSIS	984,104	3,121,008	0.315316	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4,485,637	2,420,877	1.852898	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	351,176	38,064	9.225935	90.01
91.00	09100	EMERGENCY	9,856,428	18,091,986	0.544795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,814,128	3,300,695	0.852587	92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	54,727,294	125,169,091		200.00
201.00		Less Observation Beds	2,814,128	0		201.00
202.00		Total (line 200 minus line 201)	51,913,166	125,169,091		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/29/2022 2:22 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	971,283	0	971,283	14,158	68.60	30.00
31.00	INTENSIVE CARE UNIT	264,392		264,392	3,874	68.25	31.00
40.00	SUBPROVIDER - IPF	589,070	0	589,070	7,770	75.81	40.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,824,745		1,824,745	25,802		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	2,841	194,893				30.00
31.00	INTENSIVE CARE UNIT	544	37,128				31.00
40.00	SUBPROVIDER - IPF	872	66,106				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,257	298,127				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/29/2022 2:22 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	300,668	7,032,791	0.042752	280,037	11,972	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	11,336	2,263,545	0.005008	115,192	577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,452	17,701,077	0.024205	1,155,106	27,959	54.00
60.00	06000	LABORATORY	516,678	40,668,794	0.012705	3,998,609	50,802	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	260,605	11,956,596	0.021796	1,822,594	39,725	65.00
66.00	06600	PHYSICAL THERAPY	119,741	1,721,870	0.069541	200,475	13,941	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,932	4,485,445	0.090723	683,041	61,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,580	827,043	0.030929	57,691	1,784	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,035	11,539,300	0.012655	1,856,158	23,490	73.00
74.00	07400	RENAL DIALYSIS	18,458	3,121,008	0.005914	896,160	5,300	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	310,791	2,420,877	0.128380	452	58	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	36,677	38,064	0.963561	0	0	90.01
91.00	09100	EMERGENCY	400,145	18,091,986	0.022117	576,898	12,759	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,234	3,300,695	0.044001	36,723	1,616	92.00
200.00		Total (lines 50 through 199)	3,127,332	125,169,091		11,679,136	251,951	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/29/2022 2:22 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00			
43.00	04300	NURSERY	0	0	0	0	0	43.00			
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00			
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	14,158	0.00	2,841	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	3,874	0.00	544	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	7,770	0.00	872	40.00			
43.00	04300	NURSERY	0	0	0	0.00	0	43.00			
200.00		Total (lines 30 through 199)	0	0	25,802		4,257	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/29/2022 2:22 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	7,032,791	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,263,545	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,701,077	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	40,668,794	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,956,596	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,721,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,485,445	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	827,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,539,300	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,121,008	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,420,877	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	38,064	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,091,986	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,300,695	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	125,169,091		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	280,037	0	172,788	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	115,192	0	80,807	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,155,106	0	939,725	0
60.00	06000	LABORATORY	0.000000	3,998,609	0	944,288	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	1,822,594	0	303,505	0
66.00	06600	PHYSICAL THERAPY	0.000000	200,475	0	5,282	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	683,041	0	208,935	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	57,691	0	4,446	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,856,158	0	185,892	0
74.00	07400	RENAL DIALYSIS	0.000000	896,160	0	97,152	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	452	0	246,476	0
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	3,296	0
91.00	09100	EMERGENCY	0.000000	576,898	0	893,511	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	36,723	0	448,175	0
200.00		Total (lines 50 through 199)		11,679,136	0	4,534,278	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/29/2022 2:22 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	0.552554	172,788	0	0	95,475	50.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00		
53.00	05300	ANESTHESIOLOGY	0.068476	80,807	0	0	5,533	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393731	939,725	0	0	369,999	54.00		
60.00	06000	LABORATORY	0.201301	944,288	0	0	190,086	60.00		
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30		
65.00	06500	RESPIRATORY THERAPY	0.227349	303,505	0	0	69,002	65.00		
66.00	06600	PHYSICAL THERAPY	0.824955	5,282	0	0	4,357	66.00		
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352	208,935	0	0	318,490	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495842	4,446	0	0	2,205	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489844	185,892	0	0	91,058	73.00		
74.00	07400	RENAL DIALYSIS	0.315316	97,152	0	0	30,634	74.00		
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97		
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	1.852898	246,476	0	0	456,695	90.00		
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	9.225935	3,296	0	0	30,409	90.01		
91.00	09100	EMERGENCY	0.544795	893,511	0	0	486,780	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.852587	448,175	0	0	382,108	92.00		
200.00		Subtotal (see instructions)		4,534,278	0	0	2,532,831	200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00		
202.00		Net Charges (line 200 - line 201)		4,534,278	0	0	2,532,831	202.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/29/2022 2:22 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
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
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0		90.01
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 7/29/2022 2:22 pm	
				Title XVIII	Subprovider - IPF	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	300,668	7,032,791	0.042752	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	11,336	2,263,545	0.005008	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,452	17,701,077	0.024205	21,883	530 54.00
60.00	06000	LABORATORY	516,678	40,668,794	0.012705	314,874	4,000 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	260,605	11,956,596	0.021796	10,838	236 65.00
66.00	06600	PHYSICAL THERAPY	119,741	1,721,870	0.069541	816	57 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,932	4,485,445	0.090723	4,386	398 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,580	827,043	0.030929	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,035	11,539,300	0.012655	165,279	2,092 73.00
74.00	07400	RENAL DIALYSIS	18,458	3,121,008	0.005914	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	310,791	2,420,877	0.128380	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	36,677	38,064	0.963561	0	0 90.01
91.00	09100	EMERGENCY	400,145	18,091,986	0.022117	130,289	2,882 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,300,695	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	2,982,098	125,169,091		648,365	10,195 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/29/2022 2:22 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/29/2022 2:22 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	7,032,791	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,263,545	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,701,077	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	40,668,794	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,956,596	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,721,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,485,445	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	827,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,539,300	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,121,008	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,420,877	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	38,064	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,091,986	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,300,695	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	125,169,091		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

Component CCN: 14-S103

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

Worksheet D
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,883	0	2,243	0	54.00
60.00	06000	LABORATORY	0.000000	314,874	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	10,838	0	2,621	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	816	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,386	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	165,279	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	130,289	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		648,365	0	4,864	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 7/29/2022 2:22 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.552554	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.068476	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393731	2,243	0	0	883	54.00
60.00	06000	LABORATORY	0.201301	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.227349	2,621	0	0	596	65.00
66.00	06600	PHYSICAL THERAPY	0.824955	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495842	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489844	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.315316	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1.852898	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	9.225935	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.544795	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.852587	0	0	0	0	92.00
200.00		Subtotal (see instructions)		4,864	0	0	1,479	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,864	0	0	1,479	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
7/29/2022 2:22 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Costs			
		Cost	Cost		
		Reimbursed	Reimbursed		
		Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	90.01
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	0		201.00
		Only Charges			
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/29/2022 2:22 pm

Title XIX			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	971,283	0	971,283	14,158	68.60	30.00
31.00	INTENSIVE CARE UNIT	264,392		264,392	3,874	68.25	31.00
40.00	SUBPROVIDER - IPF	589,070	0	589,070	7,770	75.81	40.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,824,745		1,824,745	25,802		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	925	63,455				
31.00	INTENSIVE CARE UNIT	425	29,006				
40.00	SUBPROVIDER - IPF	318	24,108				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	1,668	116,569				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	300,668	7,032,791	0.042752	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	11,336	2,263,545	0.005008	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,452	17,701,077	0.024205	0	0 54.00
60.00	06000	LABORATORY	516,678	40,668,794	0.012705	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	260,605	11,956,596	0.021796	0	0 65.00
66.00	06600	PHYSICAL THERAPY	119,741	1,721,870	0.069541	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,932	4,485,445	0.090723	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,580	827,043	0.030929	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,035	11,539,300	0.012655	0	0 73.00
74.00	07400	RENAL DIALYSIS	18,458	3,121,008	0.005914	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	310,791	2,420,877	0.128380	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	36,677	38,064	0.963561	0	0 90.01
91.00	09100	EMERGENCY	400,145	18,091,986	0.022117	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,234	3,300,695	0.044001	0	0 92.00
200.00		Total (lines 50 through 199)	3,127,332	125,169,091		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/29/2022 2:22 pm	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	14,158	0.00	925	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	3,874	0.00	425	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	7,770	0.00	318	40.00		
43.00	04300	NURSERY	0	0	0	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	25,802		1,668	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	0				30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00		
40.00	04000	SUBPROVIDER - IPF	0	0				40.00		
43.00	04300	NURSERY	0	0				43.00		
200.00		Total (lines 30 through 199)	0	0				200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

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

Worksheet D
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0103

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

Worksheet D
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

			Title XIX		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	7,032,791	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,263,545	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,701,077	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	40,668,794	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,956,596	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,721,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,485,445	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	827,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,539,300	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,121,008	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,420,877	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	38,064	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,091,986	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,300,695	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	125,169,091		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0 90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 7/29/2022 2:22 pm	
				Title XIX		Subprovider - IPF		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		300,668	7,032,791	0.042752	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY		11,336	2,263,545	0.005008	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		428,452	17,701,077	0.024205	0	0	54.00
60.00	06000	LABORATORY		516,678	40,668,794	0.012705	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		260,605	11,956,596	0.021796	0	0	65.00
66.00	06600	PHYSICAL THERAPY		119,741	1,721,870	0.069541	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		406,932	4,485,445	0.090723	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		25,580	827,043	0.030929	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		146,035	11,539,300	0.012655	0	0	73.00
74.00	07400	RENAL DIALYSIS		18,458	3,121,008	0.005914	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		310,791	2,420,877	0.128380	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		36,677	38,064	0.963561	0	0	90.01
91.00	09100	EMERGENCY		400,145	18,091,986	0.022117	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	3,300,695	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		2,982,098	125,169,091		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/29/2022 2:22 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/29/2022 2:22 pm	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	7,032,791	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,263,545	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,701,077	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	40,668,794	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,956,596	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,721,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,485,445	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	827,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,539,300	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,121,008	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,420,877	0.000000	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	38,064	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	18,091,986	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,300,695	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	125,169,091		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0103

Period:

Worksheet D

Component CCN: 14-S103

From 01/01/2021
To 12/31/2021Part IV
Date/Time Prepared:
7/29/2022 2:22 pm

Title XIX

Subprovider -
IPF

PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 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)			14,158	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,158	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)			12,041	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			2,841	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)			18,820,168	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)			18,820,168	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)			18,820,168	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,329.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,776,541	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,776,541	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description		Title XVIII			Hospital	PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,573,295	3,874	1,696.77	544	923,043
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,610,139
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,309,723
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					232,021
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					251,951
52.00	Total Program excludable cost (sum of lines 50 and 51)					483,972
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,825,751
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					2,117
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,329.30
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,814,128

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/29/2022 2:22 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	971,283	18,820,168	0.051609	2,814,128	145,234	90.00
91.00 Nursing Program cost	0	18,820,168	0.000000	2,814,128	0	91.00
92.00 Allied health cost	0	18,820,168	0.000000	2,814,128	0	92.00
93.00 All other Medical Education	0	18,820,168	0.000000	2,814,128	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,770	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,770	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)		7,770	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)		872	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,308,888	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,308,888	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,308,888	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,326.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,156,935	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)		1,156,935	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 pm		
			Title XVIII		Subprovider - IPF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					233,765	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,390,700	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)					66,106	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,195	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					76,301	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,314,399	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	589,070	10,308,888	0.057142	0	0 90.00
91.00	Nursing Program cost	0	10,308,888	0.000000	0	0 91.00
92.00	Allied health cost	0	10,308,888	0.000000	0	0 92.00
93.00	All other Medical Education	0	10,308,888	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XIX	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			14,158	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,158	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)			12,041	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)			925	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)			18,820,168	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)			18,820,168	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)			18,820,168	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,329.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,229,603	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)			1,229,603	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,573,295	3,874	1,696.77	425	721,127
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,950,730
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					92,461
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					92,461
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,858,269
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,117
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,329.30
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,814,128

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0103

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

Worksheet D-1

Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	971,283	18,820,168	0.051609	2,814,128	145,234
91.00	Nursing Program cost	0	18,820,168	0.000000	2,814,128	0
92.00	Allied health cost	0	18,820,168	0.000000	2,814,128	0
93.00	All other Medical Education	0	18,820,168	0.000000	2,814,128	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 pm
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,770	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,770	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)		7,770	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)		318	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,308,888	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,308,888	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,308,888	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,326.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		421,910	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)		421,910	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-S103		Date/Time Prepared: 7/29/2022 2:22 pm	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)		0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT		0	0	0.00	0	0
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						421,910
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						24,108
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0
52.00	Total Program excludable cost (sum of lines 50 and 51)						24,108
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						397,802
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0
55.00	Target amount per discharge						0.00
56.00	Target amount (line 54 x line 55)						0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0
58.00	Bonus payment (see instructions)						0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0
62.00	Relief payment (see instructions)						0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						
72.00	Program routine service cost (line 9 x line 71)						
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						
76.00	Per diem capital-related costs (line 75 ÷ line 2)						
77.00	Program capital-related costs (line 9 x line 76)						
78.00	Inpatient routine service cost (line 74 minus line 77)						
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						
81.00	Inpatient routine service cost per diem limitation						
82.00	Inpatient routine service cost limitation (line 9 x line 81)						
83.00	Reasonable inpatient routine service costs (see instructions)						
84.00	Program inpatient ancillary services (see instructions)						
85.00	Utilization review - physician compensation (see instructions)						
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XIX		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	589,070	10,308,888	0.057142	0	0 90.00
91.00	Nursing Program cost	0	10,308,888	0.000000	0	0 91.00
92.00	Allied health cost	0	10,308,888	0.000000	0	0 92.00
93.00	All other Medical Education	0	10,308,888	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/29/2022 2:22 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		4,092,605		30.00
31.00	03100	INTENSIVE CARE UNIT		2,011,400		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.552554	280,037	154,736	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.068476	115,192	7,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393731	1,155,106	454,801	54.00
60.00	06000	LABORATORY	0.201301	3,998,609	804,924	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.227349	1,822,594	414,365	65.00
66.00	06600	PHYSICAL THERAPY	0.824955	200,475	165,383	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352	683,041	1,041,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495842	57,691	28,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489844	1,856,158	909,228	73.00
74.00	07400	RENAL DIALYSIS	0.315316	896,160	282,574	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.852898	452	838	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	9.225935	0	0	90.01
91.00	09100	EMERGENCY	0.544795	576,898	314,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.852587	36,723	31,310	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,679,136	4,610,139	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)		11,679,136		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		1,069,645		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.552554	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.068476	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.393731	21,883	8,616	54.00
60.00	06000 LABORATORY	0.201301	314,874	63,384	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.227349	10,838	2,464	65.00
66.00	06600 PHYSICAL THERAPY	0.824955	816	673	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352	4,386	6,686	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.495842	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489844	165,279	80,961	73.00
74.00	07400 RENAL DIALYSIS	0.315316	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.852898	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	9.225935	0	0	90.01
91.00	09100 EMERGENCY	0.544795	130,289	70,981	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.852587	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		648,365	233,765	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		648,365		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/29/2022 2:22 pm	
Cost Center Description			Title XIX	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.552554	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.068476	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393731	0	0	54.00
60.00	06000	LABORATORY	0.201301	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.227349	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.824955	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.495842	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.489844	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.315316	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.852898	0	0	90.00
90.01	09001	PARTIAL HOSPITALIZATION PROGRAM	9.225935	0	0	90.01
91.00	09100	EMERGENCY	0.544795	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.852587	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.552554	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.068476	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.393731	0	0	54.00
60.00	06000 LABORATORY	0.201301	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.227349	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.824955	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.524352	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.495842	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.489844	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.315316	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.852898	0	0	90.00
90.01	09001 PARTIAL HOSPITALIZATION PROGRAM	9.225935	0	0	90.01
91.00	09100 EMERGENCY	0.544795	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.852587	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A
Date/Time Prepared:
7/29/2022 2:22 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)			3,544,587	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,426,799	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)			109,677	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			266,826	2.04
3.00	Managed Care Simulated Payments			4,300,862	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			108.20	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)			3.03	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)			3.03	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			4.00	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)			3.03	12.00
13.00	Total allowable FTE count for the prior year.			3.32	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.			3.03	14.00
15.00	Sum of lines 12 through 14 divided by 3.			3.13	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			3.13	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.028928	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.026227	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.026227	21.00
22.00	IME payment adjustment (see instructions)			70,738	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			61,197	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)			0.97	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)			70,738	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			61,197	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			20.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)			52.42	31.00
32.00	Sum of lines 30 and 31			73.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)			49.65	33.00
34.00	Disproportionate share adjustment (see instructions)			617,074	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)		0.000170722	0.000200626	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,415,287	1,442,907	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,058,557	363,692	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,422,249		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		7,457,950		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)			7,519,147	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			460,662	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).			80,971	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			62,610	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)			8,123,390	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			8,123,390	61.00
62.00	Deductibles billed to program beneficiaries			459,508	62.00
63.00	Coinsurance billed to program beneficiaries			51,122	63.00
64.00	Allowable bad debts (see instructions)			213,263	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			138,621	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			191,382	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			7,751,381	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-11,158	70.93
70.94	HRR adjustment amount (see instructions)			-29,567	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		80,017	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,630,639	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		7,497,802	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)		132,837	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		364,585	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/29/2022 2:22 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,544,587	0	3,544,587		3,544,587	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,426,799	0		1,426,799	1,426,799	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	109,677	0	109,677		109,677	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	266,826	0		266,826	266,826	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,300,862	0	2,881,306	1,419,556	4,300,862	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.026227	0.026227	0.026227	0.026227		5.00
6.00	IME payment adjustment (see instructions)	22.00	70,738	0	50,436	20,302	70,738	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	61,197	0	40,998	20,199	61,197	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	70,738	0	50,436	20,302	70,738	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	61,197	0	40,998	20,199	61,197	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4965	0.4965	0.4965	0.4965		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	617,074	0	439,972	177,102	617,074	11.00
11.01	Uncompensated care payments	36.00	1,422,249	0	3,924,680	0	3,924,680	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,457,950	0	5,566,921	1,891,029	7,457,950	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,519,147	0	5,607,919	1,911,228	7,519,147	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	460,662	0	322,636	138,026	460,662	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/29/2022 2:22 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	62,610	0	17,090	45,521	62,611	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,947,645	2,094,775	8,042,420	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	374,592	0	269,226	105,366	374,592	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	18,456	0	4,815	13,641	18,456	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0205	0.0205	0.0205	0.0205		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,679	0	5,519	2,160	7,679	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1600	0.1600	0.1600	0.1600		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	59,935	0	43,076	16,859	59,935	25.00
26.00	Total prospective capital payments (see instructions)	12.00	460,662	0	322,636	138,026	460,662	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.027321	0.027321		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			162,496		162,496	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				57,231	57,231	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/29/2022 2:22 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	3,544,587	3,544,587		3,544,587	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,426,799		1,426,799	1,426,799	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	109,677	109,677		109,677	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	266,826		266,826	266,826	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,300,862	2,881,306	1,419,556	4,300,862	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.026227	0.026227	0.026227		5.00
6.00	IME payment adjustment (see instructions)	22.00	70,738	50,436	20,302	70,738	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	61,197	40,998	20,199	61,197	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	70,738	50,436	20,302	70,738	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	61,197	40,998	20,199	61,197	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4965	0.4965	0.4965		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	617,074	439,972	177,102	617,074	11.00
11.01	Uncompensated care payments	36.00	1,422,249	1,058,557	363,692	1,422,249	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	7,457,950	5,203,229	2,254,721	7,457,950	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	7,519,147	5,244,227	2,274,920	7,519,147	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	460,662	322,636	138,026	460,662	16.00
17.00	Special add-on payments for new technologies	54.00	62,610	17,090	45,520	62,610	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			5,583,953	2,458,466	8,042,419	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/29/2022 2:22 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	374,592	269,226	105,366	374,592	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	18,456	4,815	13,641	18,456	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	0.0205	0.0205	0.0205		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,679	5,519	2,160	7,679	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1600	0.1600	0.1600		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	59,935	43,076	16,859	59,935	25.00
26.00	Total prospective capital payments (see instructions)	12.00	460,662	322,636	138,026	460,662	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	-11,158	-11,158	0	-11,158	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	-29,567	-22,795	-6,772	-29,567	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		55,500	24,517	80,017	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,532,831	2.00
3.00	OPPS payments		1,252,758	3.00
4.00	Outlier payment (see instructions)		29,043	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1,281,801	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)		249,297	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,032,504	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		19,177	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,051,681	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,051,681	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)		104,233	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		67,751	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		96,802	36.00
37.00	Subtotal (see instructions)		1,119,432	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)		1,119,432	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		1,221,261	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-101,829	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part B
Date/Time Prepared:
7/29/2022 2:22 pm

Title XVIII

Hospital

PPS

1.00

MEDICARE PART B ANCILLARY COSTS

200.00 Part B Combined Billed Days

0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/29/2022 2:22 pm
		Component CCN: 14-S103		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,479	2.00
3.00	OPPS payments		995	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		995	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)		199	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)		796	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)		796	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		796	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		796	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		796	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		796	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
200.00	MEDICARE PART B ANCILLARY COSTS			200.00
	Part B Combined Billed Days			

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
7/29/2022 2:22 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		6,894,770		1,032,504	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		603,032		188,757	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,497,802		1,221,261	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		132,837		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		101,829	6.02	
7.00	Total Medicare program liability (see instructions)		7,630,639		1,119,432	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0103 Component CCN: 14-S103		Period: From 01/01/2021 To 12/31/2021		Worksheet E-1 Part I Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		720,329		796	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		720,329		796	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		15,133		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		735,462		796	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: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			857,894 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			21.287671 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			857,894 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			857,894 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			857,894 18.00
19.00	Deductibles			112,708 19.00
20.00	Subtotal (line 18 minus line 19)			745,186 20.00
21.00	Coinsurance			24,857 21.00
22.00	Subtotal (line 20 minus line 21)			720,329 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			23,282 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			15,133 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,903 25.00
26.00	Subtotal (sum of lines 22 and 24)			735,462 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			735,462 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			720,329 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			15,133 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		14,141,517		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		14,141,517	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		14,141,517	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,141,517	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	LESS INPATIENT COSTS		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0103 Component CCN: 14-S103	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 7/29/2022 2:22 pm
		Title XIX	Subprovider - IPF	PPS
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	5,474,388		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,474,388	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	5,474,388	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,474,388	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			3.03	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			3.03	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.00	6.00
7.00	Enter the lesser of line 5 or line 6			3.03	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	3.90	3.90	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.95	2.95	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.95		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.32		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.03		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	3.10		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	3.10		17.00
18.00	Per resident amount	0.00	105,246.54		18.00
19.00	Approved amount for resident costs	0	326,264	326,264	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.97	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			326,264	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	4,257	3,141		26.00
27.00	Total Inpatient Days (see instructions)	23,685	23,685		27.00
28.00	Ratio of inpatient days to total inpatient days	0.179734	0.132616		28.00
29.00	Program direct GME amount	58,641	43,268	101,909	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,761	1,761	30.00
31.00	Net Program direct GME amount			100,148	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/29/2022 2:22 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		3,121,008		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		10,700,423		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		10,700,423		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		2,534,310		42.00
43.00	Primary payer payments (see instructions)		0		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		2,534,310		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		13,234,733		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.808511		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.191489		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		100,148		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		80,971		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		19,177		50.00

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

Provider CCN: 14-0103

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

Worksheet G

Date/Time Prepared:
7/29/2022 2:22 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	20,113,455	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	12,561,998	0	0	0	4.00
5.00	Other receivable	1,165,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,362,556	0	0	0	7.00
8.00	Prepaid expenses	1,169,522	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)	36,372,531	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,876,544	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	91,417,063	0	0	0	15.00
16.00	Accumulated depreciation	-55,511,023	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	60,150,794	0	0	0	23.00
24.00	Accumulated depreciation	-49,054,403	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)	53,878,975	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	27,960	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	13,973,717	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,001,677	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	104,253,183	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,562,681	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,201,708	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	5,846,703	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,611,092	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,000,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,743,137	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,743,137	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	35,354,229	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	68,898,954				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)	68,898,954	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	104,253,183	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0103

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

Worksheet G-1

Date/Time Prepared:
7/29/2022 2:22 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		73,540,197		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,187,175				2.00
3.00	Total (sum of line 1 and line 2)		68,353,022		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	TRANSFERS	545,932		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		545,932		0		10.00
11.00	Subtotal (line 3 plus line 10)		68,898,954		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)		68,898,954		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	TRANSFERS		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: 14-0103

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/29/2022 2:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,689,329		18,689,329	1.00
2.00	SUBPROVIDER - IPF	9,791,147		9,791,147	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)	28,480,476		28,480,476	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	9,180,060		9,180,060	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	9,180,060		9,180,060	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,660,536		37,660,536	17.00
18.00	Ancillary services	54,959,128		54,959,128	18.00
19.00	Outpatient services	0	70,209,962	70,209,962	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	OP PHARMACY & OTHER	220,377	3,665,393	3,885,770	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	92,840,041	73,875,355	166,715,396	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		109,453,285		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	ROUNDING	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)		109,453,285		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0103

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

Worksheet G-3

Date/Time Prepared:
7/29/2022 2:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	166,715,396	1.00
2.00	Less contractual allowances and discounts on patients' accounts	79,149,050	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,566,346	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109,453,285	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,886,939	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	105,590	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	415,299	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	20,409	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	18,172	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	47,492	24.00
24.01	ER PRO FEE INCOME	2,210,195	24.01
24.02	ANEST PRO FEE INCOME	319,544	24.02
24.03	SISTERS MAINTENANCE	0	24.03
24.04	OTHER RENTAL INCOME	388,631	24.04
24.05	OTHER	0	24.05
24.06	PARTNERS IN HEALTH	756,067	24.06
24.07	OTHER PRO FEE	1,835,104	24.07
24.08	CLINIC REVENUE	931,991	24.08
24.09	GAIN FROM DISPOSAL	0	24.09
24.10	NET ASSETS RELEASED	9,721,774	24.10
24.11	CAPITAL GAINS/LOSSES	-70,507	24.11
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	16,699,761	25.00
26.00	Total (line 5 plus line 25)	-5,187,178	26.00
27.00	RECONCILING ITEM	-3	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-3	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,187,175	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0103	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 7/29/2022 2:22 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		374,592	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		18,456	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)		43.60	3.00
4.00	Number of interns & residents (see instructions)		3.13	4.00
5.00	Indirect medical education percentage (see instructions)		2.05	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)		7,679	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		20.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		52.42	8.00
9.00	Sum of lines 7 and 8		73.26	9.00
10.00	Allowable disproportionate share percentage (see instructions)		16.00	10.00
11.00	Disproportionate share adjustment (see instructions)		59,935	11.00
12.00	Total prospective capital payments (see instructions)		460,662	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