

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: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/26/2021 8:21 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/26/2021	Time: 8:21 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THOREK MEMORIAL HOSPITAL (14-0115) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,541,315	-18,447	0	-9,157	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-1,541,315	-18,447	0	-9,157	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: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 8:21 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 850 WEST IRVING PARK ROAD			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60613		County: COOK 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		THOREK MEMORIAL HOSPITAL	140115	16974	1	07/01/1966	N	P O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)					2			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N			23.00	

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

MCRIF32 - 16.12.172.6

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 8:21 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
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
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 8:21 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	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 8:21 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,665,088	3,690,041	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB2391	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 8:21 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: THOREK HEALTH SYSTEM		Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC			Contractor's Number: 00450			141.00				
142.00	Street: 850 W. IRVING PARK ROAD		PO Box:						142.00				
143.00	City: CHICAGO		State: IL			Zip Code: 60613			143.00				
									1.00				
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00			
									1.00				
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		N		145.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					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		
161.10	CORF					N		N		N	161.10		
161.20	OUTPATIENT PHYSICAL THERAPY					N		N		N	161.20		
161.30	OUTPATIENT OCCUPATIONAL THERAPY					N		N		N	161.30		
161.40	OUTPATIENT SPEECH PATHOLOGY					N		N		N	161.40		
									1.00				
Multicampus													
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00			
				Name		County		State		Zip Code	CBSA	FTE/Campus	
				0		1.00		2.00		3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)											0.00	166.00
									1.00				
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00			
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00			
									Beginning	Ending			
									1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)										170.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/26/2021 8:21 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/26/2021 8:21 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	10/01/2020 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 nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/10/2020	Y 11/10/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		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.	HATHUY	NGUYEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 EXT 115	HATHUY.NGUYEN@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	146	53,290	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)		146	53,290	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						13.00
14.00 Total (see instructions)		156	56,940	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
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)		156				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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,862	1,168	20,214			1.00
2.00	HMO and other (see instructions)	2,158	9,644				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,862	1,168	20,214			7.00
8.00	INTENSIVE CARE UNIT	135	0	389			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	4,997	1,168	20,603	0.00	325.89	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			35			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	325.89	27.00
28.00	Observation Bed Days		0	816			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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	964	240	4,137	1.00
2.00 HMO and other (see instructions)			387	2,056		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	964	240	4,137	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	23,300,300	0	23,300,300	681,749.00	34.18
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		609,084	0	609,084	2,636.00	231.06
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		2,484,306	0	2,484,306	23,344.18	106.42
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		4,576,661	0	4,576,661	76,255.00	60.02
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,755,300	0	1,755,300	42,505.00	41.30
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		503,228	0	503,228	5,825.00	86.39
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		2,942,734	0	2,942,734	58,375.00	50.41
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)		3,254,447	0	3,254,447		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		225,564	0	225,564		
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		13,987	0	13,987		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		123,882	0	123,882		
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)		456,712	0	456,712		
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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	140,831	0	140,831	4,337.00	32.47	26.00
27.00	Administrative & General	5.00	5,083,743	0	5,083,743	106,934.00	47.54	27.00
28.00	Administrative & General under contract (see inst.)		180,290	0	180,290	854.00	211.11	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	390,979	0	390,979	11,320.00	34.54	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		768,862	0	768,862	35,349.00	21.75	33.00
34.00	Dietary	10.00	653,401	-141,258	512,143	33,827.00	15.14	34.00
35.00	Dietary under contract (see instructions)		288,122	0	288,122	3,373.00	85.42	35.00
36.00	Cafeteria	11.00	0	141,258	141,258	9,330.00	15.14	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	425,296	0	425,296	9,798.00	43.41	38.00
39.00	Central Services and Supply	14.00	75,003	0	75,003	4,838.00	15.50	39.00
40.00	Pharmacy	15.00	696,118	0	696,118	15,372.00	45.28	40.00
41.00	Medical Records & Medical Records Library	16.00	503,220	0	503,220	18,620.00	27.03	41.00
42.00	Social Service	17.00	152,798	0	152,798	2,803.00	54.51	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/26/2021 8:21 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	17,476,607	0	17,476,607	621,725.82	28.11	1.00
2.00	Excluded area salaries (see instructions)	1,755,300	0	1,755,300	42,505.00	41.30	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,721,307	0	15,721,307	579,220.82	27.14	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,445,962	0	3,445,962	64,200.00	53.68	4.00
5.00	Subtotal wage-related costs (see inst.)	3,725,146	0	3,725,146	0.00	23.69	5.00
6.00	Total (sum of lines 3 thru 5)	22,892,415	0	22,892,415	643,420.82	35.58	6.00
7.00	Total overhead cost (see instructions)	9,358,663	0	9,358,663	256,755.00	36.45	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2021 8:21 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		272,319	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)		0	8.02
8.03	Health Insurance (Purchased)		1,588,624	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		67,061	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		18,201	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		1,542	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		105,723	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		98,373	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,584,264	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		12,823	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		7,193	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,756,123	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	252,419	3,756,123	1.00
2.00	Hospital	252,419	3,374,641	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	381,482	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/26/2021 8:21 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.314729		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		12,117,944		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		47,421,921		6.00
7.00	Medicaid cost (line 1 times line 6)		14,925,054		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)		2,807,110		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)		2,807,110		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)	1,329,165	425,625	1,754,790	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	418,327	425,625	843,952	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)	418,327	425,625	843,952	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,925,724		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		547,196		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		841,840		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,083,884		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		635,774		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,479,726		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,286,836		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0115

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

Worksheet A

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		3,273,241	3,273,241	-678,309	2,594,932	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	838,629	838,629	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	140,831	3,741,420	3,882,251	0	3,882,251	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,083,743	11,339,468	16,423,211	-305,746	16,117,465	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	390,979	1,965,406	2,356,385	0	2,356,385	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	225,755	225,755	8.00
9.00	00900	HOUSEKEEPING	0	697,074	697,074	0	697,074	9.00
10.00	01000	DIETARY	653,401	781,638	1,435,039	-310,239	1,124,800	10.00
11.00	01100	CAFETERIA	0	0	0	310,239	310,239	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	425,296	53,308	478,604	0	478,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,003	257,455	332,458	-233,014	99,444	14.00
15.00	01500	PHARMACY	696,118	5,593,887	6,290,005	-5,491,363	798,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	503,220	241,330	744,550	-5	744,545	16.00
17.00	01700	SOCIAL SERVICE	152,798	4,593	157,391	-1,679	155,712	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,129,614	1,989,356	7,118,970	-401,810	6,717,160	30.00
31.00	03100	INTENSIVE CARE UNIT	416,373	64,459	480,832	-2,399	478,433	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	818,681	1,161,311	1,979,992	-180,745	1,799,247	50.00
53.00	05300	ANESTHESIOLOGY	0	546,807	546,807	-23,061	523,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,166	1,063,624	1,873,790	-44,889	1,828,901	54.00
54.01	03630	ULTRASOUND	215,679	3,094	218,773	637	219,410	54.01
60.00	06000	LABORATORY	1,037,624	1,724,184	2,761,808	-28,255	2,733,553	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	449,058	97,125	546,183	-42,421	503,762	65.00
66.00	06600	PHYSICAL THERAPY	0	112,542	112,542	0	112,542	66.00
69.00	06900	ELECTROCARDIOLOGY	42,458	50,649	93,107	-4,698	88,409	69.00
69.01	03140	CARDIAC CATH LAB	2,077	44,139	46,216	-21,647	24,569	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	865,710	865,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	428,539	428,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,382,128	5,382,128	73.00
74.00	07400	RENAL DIALYSIS	0	120,370	120,370	0	120,370	74.00
75.00	07500	ASC (NON-DISTINCT PART)	347,035	23,146	370,181	-12,475	357,706	75.00
75.01	03480	ONCOLOGY	448,836	120,311	569,147	-54,414	514,733	75.01
75.02	03340	GI LAB	0	74,621	74,621	-60,496	14,125	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,993,424	1,027,341	3,020,765	-8,664	3,012,101	90.00
90.01	09001	WOUND CARE CENTER	23,081	6,292	29,373	-5,538	23,835	90.01
91.00	09100	EMERGENCY	1,689,505	1,443,068	3,132,573	-59,441	3,073,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		80,329	80,329	-80,329	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,545,000	37,701,588	59,246,588	0	59,246,588	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,420,001	1,838,435	3,258,436	0	3,258,436	192.00
192.01	19201	RETAIL PHARMACY	275,399	1,027,398	1,302,797	0	1,302,797	192.01
192.02	19202	CHA SITES	57,210	16,090	73,300	0	73,300	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	31,803	31,803	0	31,803	192.03
194.00	07950	SENIOR HEALTH	2,690	1,713	4,403	0	4,403	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	23,300,300	40,617,027	63,917,327	0	63,917,327	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0115

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

Worksheet A

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,296	2,588,636	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	838,629	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,882,251	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,351,818	8,765,647	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-553,701	1,802,684	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	225,755	8.00
9.00	00900	HOUSEKEEPING	0	697,074	9.00
10.00	01000	DIETARY	0	1,124,800	10.00
11.00	01100	CAFETERIA	-79,745	230,494	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	478,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	99,444	14.00
15.00	01500	PHARMACY	0	798,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,111	742,434	16.00
17.00	01700	SOCIAL SERVICE	0	155,712	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-45,866	6,671,294	30.00
31.00	03100	INTENSIVE CARE UNIT	0	478,433	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-72,176	1,727,071	50.00
53.00	05300	ANESTHESIOLOGY	0	523,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,340	1,827,561	54.00
54.01	03630	ULTRASOUND	0	219,410	54.01
60.00	06000	LABORATORY	0	2,733,553	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-17,184	486,578	65.00
66.00	06600	PHYSICAL THERAPY	0	112,542	66.00
69.00	06900	ELECTROCARDIOLOGY	0	88,409	69.00
69.01	03140	CARDIAC CATH LAB	0	24,569	69.01
70.01	07001	SLEEP LAB	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	865,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	428,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,382,128	73.00
74.00	07400	RENAL DIALYSIS	0	120,370	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	357,706	75.00
75.01	03480	ONCOLOGY	-36,772	477,961	75.01
75.02	03340	GI LAB	0	14,125	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,498,484	1,513,617	90.00
90.01	09001	WOUND CARE CENTER	0	23,835	90.01
91.00	09100	EMERGENCY	-818,400	2,254,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,483,893	48,762,695	118.00
NONREIMBURSABLE COST CENTERS					
190.01	19001	SENIOR HEALTH	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,258,436	192.00
192.01	19201	RETAIL PHARMACY	0	1,302,797	192.01
192.02	19202	CHA SITES	0	73,300	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	31,803	192.03
194.00	07950	SENIOR HEALTH	0	4,403	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,483,893	53,433,434	200.00

RECLASSIFICATIONS

Provider CCN: 14-0115

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

Worksheet A-6

Date/Time Prepared:
11/26/2021 8:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION GL CC 8850-8581					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	838,629		1.00
	TOTALS		0	838,629		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	79,991		1.00
	TOTALS		0	79,991		
	C - DRUGS CHARGED					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,382,128		1.00
	TOTALS		0	5,382,128		
	D - SUPPLIES CHARGED					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	865,710		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	428,539		2.00
	PATIENTS					
3.00	ULTRASOUND	54.01	0	637		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
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	1,294,886		
	E - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	141,258	168,981		1.00
	TOTALS		141,258	168,981		
	F - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	80,329		1.00
	TOTALS		0	80,329		
	I - LAUNDRY EXP					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	225,755		1.00
	TOTALS		0	225,755		
500.00	Grand Total: Increases		141,258	8,070,699		500.00

RECLASSIFICATIONS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/26/2021 8:21 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION GL CC 8850-8581						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	838,629	9		1.00
	TOTALS		0	838,629			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,991	12		1.00
	TOTALS		0	79,991			
	C - DRUGS CHARGED						
1.00	PHARMACY	15.00	0	5,382,128	0		1.00
	TOTALS		0	5,382,128			
	D - SUPPLIES CHARGED						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	233,014	0		1.00
2.00	PHARMACY	15.00	0	109,235	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	5	0		3.00
4.00	SOCIAL SERVICE	17.00	0	1,679	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	401,810	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	2,399	0		6.00
7.00	OPERATING ROOM	50.00	0	180,745	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	23,061	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,889	0		9.00
11.00	LABORATORY	60.00	0	28,255	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	42,421	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	4,698	0		13.00
14.00	CARDIAC CATH LAB	69.01	0	21,647	0		14.00
15.00	ASC (NON-DISTINCT PART)	75.00	0	12,475	0		15.00
16.00	ONCOLOGY	75.01	0	54,414	0		16.00
17.00	GI LAB	75.02	0	60,496	0		17.00
18.00	CLINIC	90.00	0	8,664	0		18.00
19.00	WOUND CARE CENTER	90.01	0	5,538	0		19.00
20.00	EMERGENCY	91.00	0	59,441	0		20.00
	TOTALS		0	1,294,886			
	E - CAFETERIA COSTS						
1.00	DIETARY	10.00	141,258	168,981	0		1.00
	TOTALS		141,258	168,981			
	F - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	80,329	11		1.00
	TOTALS		0	80,329			
	I - LAUNDRY EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	225,755	0		1.00
	TOTALS		0	225,755			
500.00	Grand Total: Decreases		141,258	8,070,699			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	14,137,215	0	0	0	0	1.00	
2.00	Land Improvements	1,628,949	0	0	0	0	2.00	
3.00	Buildings and Fixtures	40,791,751	0	0	0	0	3.00	
4.00	Building Improvements	24,620,182	5,051,244	0	5,051,244	0	4.00	
5.00	Fixed Equipment	14,319,484	0	0	0	10,552	5.00	
6.00	Movable Equipment	27,632,383	495,830	0	495,830	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	123,129,964	5,547,074	0	5,547,074	10,552	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	123,129,964	5,547,074	0	5,547,074	10,552	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	14,137,215	0				1.00	
2.00	Land Improvements	1,628,949	0				2.00	
3.00	Buildings and Fixtures	40,791,751	0				3.00	
4.00	Building Improvements	29,671,426	0				4.00	
5.00	Fixed Equipment	14,308,932	0				5.00	
6.00	Movable Equipment	28,128,213	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	128,666,486	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	128,666,486	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,273,241	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)	3,273,241	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	3,273,241				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	3,273,241				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	100,538,273	0	100,538,273	0.781387	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	28,128,213	0	28,128,213	0.218613	0	2.00
3.00	Total (sum of lines 1-2)	128,666,486	0	128,666,486	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	2,434,612	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	838,629	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,273,241	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	74,033	79,991	0	0	2,588,636	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	838,629	2.00
3.00	Total (sum of lines 1-2)	74,033	79,991	0	0	3,427,265	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0115

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

Worksheet A-8

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-6,296	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)	B	-4,904	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-20,889	ADMINISTRATIVE & GENERAL	5.00	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	-2,843,552			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	-2,273,377			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-79,745	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	-2,111	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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	00R	B	-1,340	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0115

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

Worksheet A-8

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	00R	B	-631,076	ADMINISTRATIVE & GENERAL	5.00	0	33.01
41.00	HOSPITALITY EXP	A	-84,295	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	HOSPITALITY EXP	A	-11,586	OPERATION OF PLANT	7.00	0	41.01
41.03	HOSPITALITY EXP		0		0.00	0	41.03
41.05	HOSPITALITY EXP	A	-4,576	CLINIC	90.00	0	41.05
42.01	LDUES -LOBBYING PORTION	A	-13,858	ADMINISTRATIVE & GENERAL	5.00	0	42.01
42.02	MARKETING EXP	A	-66,189	ADMINISTRATIVE & GENERAL	5.00	0	42.02
42.03	MEDICARE PREMIUM FOR RETIRED EM		0		0.00	0	42.03
44.00	ADVERTISING EXP	A	-8,252	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.02	ADVERTISING EXP		0		0.00	0	44.02
45.00	MEDICAID ASSESSMENT TAX	A	-4,431,847	ADMINISTRATIVE & GENERAL	5.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,483,893				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0115

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2021 8:21 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL		5,033,061	6,764,323	2.00
3.00	7.00	OPERATION OF PLANT		1,381,042	1,923,157	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,414,103	8,687,480	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0115

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2021 8:21 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	-1,731,262	0		2.00
3.00	-542,115	0		3.00
4.00	0	0		4.00
5.00	-2,273,377			5.00

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

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

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

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

6.00	CORPORATION		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0115

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2021 8:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.00	AGGREGATE-SOCIAL SERVICE	47,184	0	47,184	211,500	643	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	45,866	45,866	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	72,176	72,176	0	0	0	3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	17,184	17,184	0	0	0	4.00
5.00	75.01	AGGREGATE-ONCOLOGY	36,772	36,772	0	0	0	5.00
6.00	90.00	AGGREGATE-CLINIC	1,493,908	1,493,908	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	818,400	818,400	0	0	0	7.00
8.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	561,900	0	561,900	211,500	1,993	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,093,390	2,484,306	609,084		2,636	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	17.00	AGGREGATE-SOCIAL SERVICE	65,382	3,269	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	75.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	5.00
6.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	7.00
8.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	202,654	10,133	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			268,036	13,402	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	17.00	AGGREGATE-SOCIAL SERVICE	0	65,382	0	0		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	45,866		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	72,176		3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	17,184		4.00
5.00	75.01	AGGREGATE-ONCOLOGY	0	0	0	36,772		5.00
6.00	90.00	AGGREGATE-CLINIC	0	0	0	1,493,908		6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	0	0	818,400		7.00
8.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	202,654	359,246	359,246		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	268,036	359,246	2,843,552		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,588,636	2,588,636			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	838,629	838,629			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,882,251	4,043	1,310	3,887,604	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,765,647	146,332	47,407	853,367	9,812,753
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,802,684	545,951	176,868	65,631	2,591,134
8.00	00800	LAUNDRY & LINEN SERVICE	225,755	0	0	0	225,755
9.00	00900	HOUSEKEEPING	697,074	8,176	2,649	0	707,899
10.00	01000	DIETARY	1,124,800	69,802	22,614	85,969	1,303,185
11.00	01100	CAFETERIA	230,494	30,673	9,937	23,712	294,816
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	478,604	0	0	71,391	549,995
14.00	01400	CENTRAL SERVICES & SUPPLY	99,444	85,268	27,624	12,590	224,926
15.00	01500	PHARMACY	798,642	11,231	3,639	116,852	930,364
16.00	01600	MEDICAL RECORDS & LIBRARY	742,434	33,559	10,872	84,472	871,337
17.00	01700	SOCIAL SERVICE	155,712	0	0	25,649	181,361
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,671,294	472,679	153,132	861,076	8,158,181
31.00	03100	INTENSIVE CARE UNIT	478,433	35,783	11,592	69,893	595,701
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,727,071	83,695	27,114	137,425	1,975,305
53.00	05300	ANESTHESIOLOGY	523,746	3,628	1,175	0	528,549
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,827,561	97,802	31,684	135,996	2,093,043
54.01	03630	ULTRASOUND	219,410	2,527	819	36,204	258,960
60.00	06000	LABORATORY	2,733,553	61,581	19,950	174,178	2,989,262
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	486,578	33,727	10,927	75,380	606,612
66.00	06600	PHYSICAL THERAPY	112,542	29,134	9,438	0	151,114
69.00	06900	ELECTROCARDIOLOGY	88,409	2,190	710	7,127	98,436
69.01	03140	CARDIAC CATH LAB	24,569	17,408	5,640	349	47,966
70.01	07001	SLEEP LAB	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	865,710	0	0	0	865,710
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	428,539	0	0	0	428,539
73.00	07300	DRUGS CHARGED TO PATIENTS	5,382,128	0	0	0	5,382,128
74.00	07400	RENAL DIALYSIS	120,370	786	255	0	121,411
75.00	07500	ASC (NON-DISTINCT PART)	357,706	92,006	29,807	58,254	537,773
75.01	03480	ONCOLOGY	477,961	50,923	16,497	75,343	620,724
75.02	03340	GI LAB	14,125	20,194	6,542	0	40,861
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,513,617	65,770	21,307	334,620	1,935,314
90.01	09001	WOUND CARE CENTER	23,835	9,547	3,093	3,874	40,349
91.00	09100	EMERGENCY	2,254,732	38,748	12,553	283,604	2,589,637
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,762,695	2,053,163	665,155	3,592,956	47,759,100
NONREIMBURSABLE COST CENTERS							
190.01	19001	SENIOR HEALTH	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,258,436	14,309	4,635	238,364	3,515,744
192.01	19201	RETAIL PHARMACY	1,302,797	4,043	1,310	46,229	1,354,379
192.02	19202	CHA SITES	73,300	517,121	167,529	9,603	767,553
192.03	19203	OTHER NON REIMBURSABLE	31,803	0	0	0	31,803
194.00	07950	SENIOR HEALTH	4,403	0	0	452	4,855
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118 through 201)	53,433,434	2,588,636	838,629	3,887,604	53,433,434	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 8:21 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	9,812,753					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	582,891	0	3,174,025			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,785	0	0	276,540		8.00
9.00	00900	HOUSEKEEPING	159,246	0	13,714	0	880,859	9.00
10.00	01000	DIETARY	293,159	0	117,081	0	32,564	10.00
11.00	01100	CAFETERIA	66,321	0	51,448	0	14,309	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	123,725	0	0	0	1,871	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,598	0	143,022	0	39,779	14.00
15.00	01500	PHARMACY	209,291	0	18,839	0	5,240	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	196,012	0	56,289	0	15,656	16.00
17.00	01700	SOCIAL SERVICE	40,798	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,835,251	0	792,837	174,933	220,515	30.00
31.00	03100	INTENSIVE CARE UNIT	134,007	0	60,019	6,398	16,693	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	444,357	0	140,385	7,854	39,046	50.00
53.00	05300	ANESTHESIOLOGY	118,900	0	6,085	0	1,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	470,843	0	164,046	36,903	45,627	54.00
54.01	03630	ULTRASOUND	58,255	0	4,239	0	1,179	54.01
60.00	06000	LABORATORY	672,452	0	103,292	0	28,729	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	136,461	0	56,572	0	15,735	65.00
66.00	06600	PHYSICAL THERAPY	33,994	0	48,867	0	13,592	66.00
69.00	06900	ELECTROCARDIOLOGY	22,144	0	3,674	0	1,022	69.00
69.01	03140	CARDIAC CATH LAB	10,790	0	29,200	0	8,121	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,747	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,402	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,210,742	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	27,312	0	1,319	0	367	74.00
75.00	07500	ASC (NON-DISTINCT PART)	120,975	0	154,325	4,863	42,923	75.00
75.01	03480	ONCOLOGY	139,636	0	85,414	0	23,756	75.01
75.02	03340	GI LAB	9,192	0	33,872	0	9,421	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	435,360	0	110,318	0	30,683	90.00
90.01	09001	WOUND CARE CENTER	9,077	0	16,013	0	4,454	90.01
91.00	09100	EMERGENCY	582,554	0	64,993	45,589	18,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,536,277	0	2,275,863	276,540	631,051	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	790,888	0	24,000	0	6,675	192.00
192.01	19201	RETAIL PHARMACY	304,676	0	6,782	0	1,886	192.01
192.02	19202	CHA SITES	172,666	0	867,380	0	241,247	192.02
192.03	19203	OTHER NON REIMBURSABLE	7,154	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	1,092	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,812,753	0	3,174,025	276,540	880,859	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/26/2021 8:21 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	1,745,989					10.00
11.00	01100	CAFETERIA	341,465	768,359				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	14,564	0	690,155		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,205	0	0	465,530	14.00
15.00	01500	PHARMACY	0	22,851	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,674	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,174	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,378,011	289,980	0	467,886	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,513	16,697	0	26,942	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	35,281	0	56,927	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,272	0	0	0	54.00
54.01	03630	ULTRASOUND	0	25,819	0	0	0	54.01
60.00	06000	LABORATORY	0	70,253	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	22,047	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,824	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	62	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	311,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	154,142	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
75.00	07500	ASC (NON-DISTINCT PART)	0	13,265	0	21,404	0	75.00
75.01	03480	ONCOLOGY	0	21,768	0	35,124	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	47,835	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	1,020	0	3,093	0	90.01
91.00	09100	EMERGENCY	0	51,298	0	78,779	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,745,989	703,889	0	690,155	465,530	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,783	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	10,884	0	0	0	192.01
192.02	19202	CHA SITES	0	3,556	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	247	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,745,989	768,359	0	690,155	465,530	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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	1,186,585					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,166,968				16.00
17.00	01700	SOCIAL SERVICE	0	0	226,333			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	266,913	135,800	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,549	45,267	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	17,965	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,715	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,742	103,856	0	0	0	54.00
54.01	03630	ULTRASOUND	0	18,149	0	0	0	54.01
60.00	06000	LABORATORY	0	146,789	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	67,193	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	549	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	18,893	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	1,243	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,129	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,835	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,027,871	277,215	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,970	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	14,445	0	0	0	75.00
75.01	03480	ONCOLOGY	0	40,846	22,633	0	0	75.01
75.02	03340	GI LAB	0	17,466	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	34,960	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	1,992	0	0	0	90.01
91.00	09100	EMERGENCY	0	47,296	22,633	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,036,613	1,166,968	226,333	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	149,972	0	0	0	0	192.01
192.02	19202	CHA SITES	0	0	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,186,585	1,166,968	226,333	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	13,720,307	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	937,786	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,717,120	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	664,941	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,953,332	0	54.00
54.01	03630	ULTRASOUND	0	0	0	366,601	0	54.01
60.00	06000	LABORATORY	0	0	0	4,010,777	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	904,620	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	248,116	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	145,993	0	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	97,382	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,417,974	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	701,918	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,897,956	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	153,379	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	909,973	0	75.00
75.01	03480	ONCOLOGY	0	0	0	989,901	0	75.01
75.02	03340	GI LAB	0	0	0	110,812	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,594,470	0	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	75,998	0	90.01
91.00	09100	EMERGENCY	0	0	0	3,500,856	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	45,120,212	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	4,387,090	0	192.00
192.01	19201	RETAIL PHARMACY	0	0	0	1,828,579	0	192.01
192.02	19202	CHA SITES	0	0	0	2,052,402	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	38,957	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	6,194	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00		24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	0	0	0	53,433,434	0
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03140	CARDIAC CATH LAB	69.01
70.01	07001	SLEEP LAB	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03480	ONCOLOGY	75.01
75.02	03340	GI LAB	75.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE CENTER	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.01	19001	SENIOR HEALTH	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	RETAIL PHARMACY	192.01
192.02	19202	CHA SITES	192.02
192.03	19203	OTHER NON REIMBURSABLE	192.03
194.00	07950	SENIOR HEALTH	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,043	1,310	5,353	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	146,332	47,407	193,739	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	545,951	176,868	722,819	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,176	2,649	10,825	9.00
10.00	01000	DIETARY	0	69,802	22,614	92,416	10.00
11.00	01100	CAFETERIA	0	30,673	9,937	40,610	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	85,268	27,624	112,892	14.00
15.00	01500	PHARMACY	0	11,231	3,639	14,870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,559	10,872	44,431	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	472,679	153,132	625,811	30.00
31.00	03100	INTENSIVE CARE UNIT	0	35,783	11,592	47,375	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	83,695	27,114	110,809	50.00
53.00	05300	ANESTHESIOLOGY	0	3,628	1,175	4,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,802	31,684	129,486	54.00
54.01	03630	ULTRASOUND	0	2,527	819	3,346	54.01
60.00	06000	LABORATORY	0	61,581	19,950	81,531	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	33,727	10,927	44,654	65.00
66.00	06600	PHYSICAL THERAPY	0	29,134	9,438	38,572	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,190	710	2,900	69.00
69.01	03140	CARDIAC CATH LAB	0	17,408	5,640	23,048	69.01
70.01	07001	SLEEP LAB	0	0	0	0	70.01
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	786	255	1,041	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	92,006	29,807	121,813	75.00
75.01	03480	ONCOLOGY	0	50,923	16,497	67,420	75.01
75.02	03340	GI LAB	0	20,194	6,542	26,736	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	65,770	21,307	87,077	90.00
90.01	09001	WOUND CARE CENTER	0	9,547	3,093	12,640	90.01
91.00	09100	EMERGENCY	0	38,748	12,553	51,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,053,163	665,155	2,718,318	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	SENIOR HEALTH	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,309	4,635	18,944	192.00
192.01	19201	RETAIL PHARMACY	0	4,043	1,310	5,353	192.01
192.02	19202	CHA SITES	0	517,121	167,529	684,650	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,588,636	838,629	3,427,265	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 8:21 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	194,913					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	11,577	0	734,486			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,009	0	0	1,009		8.00
9.00	00900	HOUSEKEEPING	3,163	0	3,174	0	17,162	9.00
10.00	01000	DIETARY	5,823	0	27,093	0	634	10.00
11.00	01100	CAFETERIA	1,317	0	11,905	0	279	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,457	0	0	0	36	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,005	0	33,096	0	775	14.00
15.00	01500	PHARMACY	4,157	0	4,359	0	102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,893	0	13,026	0	305	16.00
17.00	01700	SOCIAL SERVICE	810	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,468	0	183,467	638	4,296	30.00
31.00	03100	INTENSIVE CARE UNIT	2,662	0	13,889	23	325	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,826	0	32,486	29	761	50.00
53.00	05300	ANESTHESIOLOGY	2,362	0	1,408	0	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,352	0	37,961	135	889	54.00
54.01	03630	ULTRASOUND	1,157	0	981	0	23	54.01
60.00	06000	LABORATORY	13,356	0	23,902	0	560	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,710	0	13,091	0	307	65.00
66.00	06600	PHYSICAL THERAPY	675	0	11,308	0	265	66.00
69.00	06900	ELECTROCARDIOLOGY	440	0	850	0	20	69.00
69.01	03140	CARDIAC CATH LAB	214	0	6,757	0	158	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,868	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,915	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,047	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	542	0	305	0	7	74.00
75.00	07500	ASC (NON-DISTINCT PART)	2,403	0	35,712	18	836	75.00
75.01	03480	ONCOLOGY	2,773	0	19,765	0	463	75.01
75.02	03340	GI LAB	183	0	7,838	0	184	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,647	0	25,528	0	598	90.00
90.01	09001	WOUND CARE CENTER	180	0	3,705	0	87	90.01
91.00	09100	EMERGENCY	11,570	0	15,040	166	352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,561	0	526,646	1,009	12,295	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,708	0	5,554	0	130	192.00
192.01	19201	RETAIL PHARMACY	6,051	0	1,569	0	37	192.01
192.02	19202	CHA SITES	3,429	0	200,717	0	4,700	192.02
192.03	19203	OTHER NON REIMBURSABLE	142	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	22	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	194,913	0	734,486	1,009	17,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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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	126,084					10.00
11.00	01100	CAFETERIA	24,658	78,802				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,494	0	4,085		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	739	0	0	148,524	14.00
15.00	01500	PHARMACY	0	2,344	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,838	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	428	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	99,511	29,740	0	2,770	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,915	1,712	0	159	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,618	0	337	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,105	0	0	0	54.00
54.01	03630	ULTRASOUND	0	2,648	0	0	0	54.01
60.00	06000	LABORATORY	0	7,205	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	2,261	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	187	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0	6	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	99,346	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	49,178	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
75.00	07500	ASC (NON-DISTINCT PART)	0	1,360	0	127	0	75.00
75.01	03480	ONCOLOGY	0	2,233	0	208	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,906	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0	105	0	18	0	90.01
91.00	09100	EMERGENCY	0	5,261	0	466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,084	72,190	0	4,085	148,524	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,106	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	1,116	0	0	0	192.01
192.02	19202	CHA SITES	0	365	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	25	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	126,084	78,802	0	4,085	148,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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	25,993					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,609				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,273			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	14,788	764			30.00
31.00	03100	INTENSIVE CARE UNIT	0	529	255			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	995	0			50.00
53.00	05300	ANESTHESIOLOGY	0	538	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	192	5,754	0			54.00
54.01	03630	ULTRASOUND	0	1,006	0			54.01
60.00	06000	LABORATORY	0	8,133	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	3,723	0			65.00
66.00	06600	PHYSICAL THERAPY	0	30	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,047	0			69.00
69.01	03140	CARDIAC CATH LAB	0	69	0			69.01
70.01	07001	SLEEP LAB	0	0	0			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,556	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,265	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,515	15,313	0			73.00
74.00	07400	RENAL DIALYSIS	0	165	0			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	800	0			75.00
75.01	03480	ONCOLOGY	0	2,263	127			75.01
75.02	03340	GI LAB	0	968	0			75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,937	0			90.00
90.01	09001	WOUND CARE CENTER	0	110	0			90.01
91.00	09100	EMERGENCY	0	2,620	127			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,707	64,609	1,273	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0			190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0			192.00
192.01	19201	RETAIL PHARMACY	3,286	0	0			192.01
192.02	19202	CHA SITES	0	0	0			192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0			192.03
194.00	07950	SENIOR HEALTH	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,993	64,609	1,273	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				999,443	0	30.00
31.00	03100	INTENSIVE CARE UNIT				68,940	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				158,050	0	50.00
53.00	05300	ANESTHESIOLOGY				9,144	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				187,061	0	54.00
54.01	03630	ULTRASOUND				9,211	0	54.01
60.00	06000	LABORATORY				134,927	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				66,850	0	65.00
66.00	06600	PHYSICAL THERAPY				50,850	0	66.00
69.00	06900	ELECTROCARDIOLOGY				5,454	0	69.00
69.01	03140	CARDIAC CATH LAB				30,252	0	69.01
70.01	07001	SLEEP LAB				0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				105,770	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				52,358	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				61,875	0	73.00
74.00	07400	RENAL DIALYSIS				2,060	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)				163,149	0	75.00
75.01	03480	ONCOLOGY				95,356	0	75.01
75.02	03340	GI LAB				35,909	0	75.02
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				129,153	0	90.00
90.01	09001	WOUND CARE CENTER				16,850	0	90.01
91.00	09100	EMERGENCY				87,293	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	2,469,955	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH				0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES				45,770	0	192.00
192.01	19201	RETAIL PHARMACY				17,476	0	192.01
192.02	19202	CHA SITES				893,874	0	192.02
192.03	19203	OTHER NON REIMBURSABLE				142	0	192.03
194.00	07950	SENIOR HEALTH				48	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00		24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	0	0	0	3,427,265	0
						202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03140	CARDIAC CATH LAB	69.01
70.01	07001	SLEEP LAB	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03480	ONCOLOGY	75.01
75.02	03340	GI LAB	75.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE CENTER	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.01	19001	SENIOR HEALTH	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	RETAIL PHARMACY	192.01
192.02	19202	CHA SITES	192.02
192.03	19203	OTHER NON REIMBURSABLE	192.03
194.00	07950	SENIOR HEALTH	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	230,485				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		230,485			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	360	360	23,159,469		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,029	13,029	5,083,743	-9,812,753	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	48,610	48,610	390,979	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	728	728	0	0	9.00
10.00	01000	DIETARY	6,215	6,215	512,143	0	10.00
11.00	01100	CAFETERIA	2,731	2,731	141,258	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	425,296	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,592	7,592	75,003	0	14.00
15.00	01500	PHARMACY	1,000	1,000	696,118	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,988	2,988	503,220	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	152,798	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,086	42,086	5,129,614	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,186	3,186	416,373	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,452	7,452	818,681	0	50.00
53.00	05300	ANESTHESIOLOGY	323	323	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,708	8,708	810,166	0	54.00
54.01	03630	ULTRASOUND	225	225	215,679	0	54.01
60.00	06000	LABORATORY	5,483	5,483	1,037,624	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,003	3,003	449,058	0	65.00
66.00	06600	PHYSICAL THERAPY	2,594	2,594	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	195	195	42,458	0	69.00
69.01	03140	CARDIAC CATH LAB	1,550	1,550	2,077	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	70.01
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	70	70	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	8,192	8,192	347,035	0	75.00
75.01	03480	ONCOLOGY	4,534	4,534	448,836	0	75.01
75.02	03340	GI LAB	1,798	1,798	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,856	5,856	1,993,424	0	90.00
90.01	09001	WOUND CARE CENTER	850	850	23,081	0	90.01
91.00	09100	EMERGENCY	3,450	3,450	1,689,505	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	182,808	182,808	21,404,169	-9,812,753	118.00
NONREIMBURSABLE COST CENTERS							
190.01	19001	SENIOR HEALTH	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,274	1,274	1,420,001	0	192.00
192.01	19201	RETAIL PHARMACY	360	360	275,399	0	192.01
192.02	19202	CHA SITES	46,043	46,043	57,210	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	2,690	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,588,636	838,629	3,887,604		9,812,753	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.231256	3.638540	0.167862		0.224956	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,353		194,913	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000231		0.004468	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	168,486				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	529,831			8.00
9.00	00900	HOUSEKEEPING	0	728	0	168,115		9.00
10.00	01000	DIETARY	0	6,215	0	6,215	97,136	10.00
11.00	01100	CAFETERIA	0	2,731	0	2,731	18,997	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	357	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,592	0	7,592	0	14.00
15.00	01500	PHARMACY	0	1,000	0	1,000	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,988	0	2,988	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	42,086	335,159	42,086	76,664	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,186	12,258	3,186	1,475	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,452	15,048	7,452	0	50.00
53.00	05300	ANESTHESIOLOGY	0	323	0	323	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,708	70,704	8,708	0	54.00
54.01	03630	ULTRASOUND	0	225	0	225	0	54.01
60.00	06000	LABORATORY	0	5,483	0	5,483	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,003	0	3,003	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,594	0	2,594	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	195	0	195	0	69.00
69.01	03140	CARDIAC CATH LAB	0	1,550	0	1,550	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
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	70	0	70	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	8,192	9,317	8,192	0	75.00
75.01	03480	ONCOLOGY	0	4,534	0	4,534	0	75.01
75.02	03340	GI LAB	0	1,798	0	1,798	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,856	0	5,856	0	90.00
90.01	09001	WOUND CARE CENTER	0	850	0	850	0	90.01
91.00	09100	EMERGENCY	0	3,450	87,345	3,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	120,809	529,831	120,438	97,136	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,274	0	1,274	0	192.00
192.01	19201	RETAIL PHARMACY	0	360	0	360	0	192.01
192.02	19202	CHA SITES	0	46,043	0	46,043	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	3,174,025	276,540	880,859	1,745,989	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	18.838509	0.521940	5.239622	17.974685	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	734,486	1,009	17,162	126,084	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.359330	0.001904	0.102085	1.298015	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			CAFETERIA (FTE'S)	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	24,849					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	471	0	13,833			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233	0	0	1,294,249		14.00
15.00	01500	PHARMACY	739	0	0	0	6,213,181	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	895	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	135	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,378	0	9,378	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	540	0	540	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,141	0	1,141	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	979	0	0	0	45,774	54.00
54.01	03630	ULTRASOUND	835	0	0	0	0	54.01
60.00	06000	LABORATORY	2,272	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	713	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	59	0	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	2	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	865,710	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	428,539	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,382,128	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	429	0	429	0	0	75.00
75.01	03480	ONCOLOGY	704	0	704	0	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,547	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	33	0	62	0	0	90.01
91.00	09100	EMERGENCY	1,659	0	1,579	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,764	0	13,833	1,294,249	5,427,902	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,610	0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	352	0	0	0	785,279	192.01
192.02	19202	CHA SITES	115	0	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	8	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	768,359	0	690,155	465,530	1,186,585	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	30.921124	0.000000	49.891925	0.359691	0.190979	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,802	0	4,085	148,524	25,993	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.171234	0.000000	0.295308	0.114757	0.004184	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: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
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	143,361,905					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,790,321	60	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,173,114	20	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,206,953	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1,193,507	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,758,673	0	0	0	0	54.00
54.01	03630	ULTRASOUND	2,229,609	0	0	0	0	54.01
60.00	06000	LABORATORY	18,033,024	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	8,254,682	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	67,418	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,321,062	0	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	152,668	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,666,979	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,805,237	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,055,754	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	364,816	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	1,774,599	0	0	0	0	75.00
75.01	03480	ONCOLOGY	5,017,977	10	0	0	0	75.01
75.02	03340	GI LAB	2,145,728	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,294,797	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	244,677	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,810,310	10	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,361,905	100	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.01	19001	SENIOR HEALTH	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RETAIL PHARMACY	0	0	0	0	0	192.01
192.02	19202	CHA SITES	0	0	0	0	0	192.02
192.03	19203	OTHER NON REIMBURSABLE	0	0	0	0	0	192.03
194.00	07950	SENIOR HEALTH	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,166,968	226,333	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008140	2,263.330000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,609	1,273	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000451	12.730000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			23.00
			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	
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00	
20.00	02000	NURSING SCHOOL			20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01	03630	ULTRASOUND	0	0	54.01	
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	
69.01	03140	CARDIAC CATH LAB	0	0	69.01	
70.01	07001	SLEEP LAB	0	0	70.01	
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	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00	
75.01	03480	ONCOLOGY	0	0	75.01	
75.02	03340	GI LAB	0	0	75.02	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	90.00	
90.01	09001	WOUND CARE CENTER	0	0	90.01	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00	
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE			113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00	
NONREIMBURSABLE COST CENTERS						
190.01	19001	SENIOR HEALTH	0	0	190.01	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00	
192.01	19201	RETAIL PHARMACY	0	0	192.01	
192.02	19202	CHA SITES	0	0	192.02	
192.03	19203	OTHER NON REIMBURSABLE	0	0	192.03	
194.00	07950	SENIOR HEALTH	0	0	194.00	
200.00		Cross Foot Adjustments			200.00	
201.00		Negative Cost Centers			201.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0115

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

Worksheet B-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
					Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	13,720,307		13,720,307	0	13,720,307	30.00	
31.00	03100	INTENSIVE CARE UNIT	937,786		937,786	0	937,786	31.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,717,120		2,717,120	0	2,717,120	50.00	
53.00	05300	ANESTHESIOLOGY	664,941		664,941	0	664,941	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,953,332		2,953,332	0	2,953,332	54.00	
54.01	03630	ULTRASOUND	366,601		366,601	0	366,601	54.01	
60.00	06000	LABORATORY	4,010,777		4,010,777	0	4,010,777	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	904,620	0	904,620	0	904,620	65.00	
66.00	06600	PHYSICAL THERAPY	248,116	0	248,116	0	248,116	66.00	
69.00	06900	ELECTROCARDIOLOGY	145,993		145,993	0	145,993	69.00	
69.01	03140	CARDIAC CATH LAB	97,382		97,382	0	97,382	69.01	
70.01	07001	SLEEP LAB	0		0	0	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,417,974		1,417,974	0	1,417,974	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	701,918		701,918	0	701,918	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	7,897,956		7,897,956	0	7,897,956	73.00	
74.00	07400	RENAL DIALYSIS	153,379		153,379	0	153,379	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	909,973		909,973	0	909,973	75.00	
75.01	03480	ONCOLOGY	989,901		989,901	0	989,901	75.01	
75.02	03340	GI LAB	110,812		110,812	0	110,812	75.02	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,594,470		2,594,470	0	2,594,470	90.00	
90.01	09001	WOUND CARE CENTER	75,998		75,998	0	75,998	90.01	
91.00	09100	EMERGENCY	3,500,856		3,500,856	0	3,500,856	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	532,375		532,375	0	532,375	92.00	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	45,652,587	0	45,652,587	0	45,652,587	200.00	
201.00		Less Observation Beds	532,375		532,375		532,375	201.00	
202.00		Total (see instructions)	45,120,212	0	45,120,212	0	45,120,212	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

			Title XVIII		Hospital	PPS		
	Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,116,615		31,116,615			30.00
31.00	03100	INTENSIVE CARE UNIT	1,173,114		1,173,114			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	621,044	1,585,909	2,206,953	1.231164	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	261,624	931,883	1,193,507	0.557132	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,308,450	9,450,223	12,758,673	0.231476	0.000000	54.00
54.01	03630	ULTRASOUND	569,674	1,659,935	2,229,609	0.164424	0.000000	54.01
60.00	06000	LABORATORY	10,395,213	7,637,811	18,033,024	0.222413	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	7,484,075	770,607	8,254,682	0.109589	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	64,132	3,286	67,418	3.680263	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	899,448	1,421,614	2,321,062	0.062899	0.000000	69.00
69.01	03140	CARDIAC CATH LAB	1,720	150,948	152,668	0.637868	0.000000	69.01
70.01	07001	SLEEP LAB	0	0	0	0.000000	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,198,032	3,468,947	5,666,979	0.250217	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,163,321	1,641,916	2,805,237	0.250217	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,769,034	22,286,720	34,055,754	0.231913	0.000000	73.00
74.00	07400	RENAL DIALYSIS	282,942	81,874	364,816	0.420428	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	165,813	1,608,786	1,774,599	0.512777	0.000000	75.00
75.01	03480	ONCOLOGY	39,970	4,978,007	5,017,977	0.197271	0.000000	75.01
75.02	03340	GI LAB	154,654	1,991,074	2,145,728	0.051643	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,270	4,288,527	4,294,797	0.604096	0.000000	90.00
90.01	09001	WOUND CARE CENTER	9,222	235,455	244,677	0.310605	0.000000	90.01
91.00	09100	EMERGENCY	2,794,308	3,016,002	5,810,310	0.602525	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,696	1,646,010	1,673,706	0.318082	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	74,506,371	68,855,534	143,361,905			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,506,371	68,855,534	143,361,905			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/26/2021 8:21 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.231164		50.00
53.00	05300	ANESTHESIOLOGY	0.557132		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231476		54.00
54.01	03630	ULTRASOUND	0.164424		54.01
60.00	06000	LABORATORY	0.222413		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.109589		65.00
66.00	06600	PHYSICAL THERAPY	3.680263		66.00
69.00	06900	ELECTROCARDIOLOGY	0.062899		69.00
69.01	03140	CARDIAC CATH LAB	0.637868		69.01
70.01	07001	SLEEP LAB	0.000000		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250217		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250217		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231913		73.00
74.00	07400	RENAL DIALYSIS	0.420428		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.512777		75.00
75.01	03480	ONCOLOGY	0.197271		75.01
75.02	03340	GI LAB	0.051643		75.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.604096		90.00
90.01	09001	WOUND CARE CENTER	0.310605		90.01
91.00	09100	EMERGENCY	0.602525		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.318082		92.00
	OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,720,307		13,720,307	0
31.00	03100	INTENSIVE CARE UNIT	937,786		937,786	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,717,120		2,717,120	0
53.00	05300	ANESTHESIOLOGY	664,941		664,941	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,953,332		2,953,332	0
54.01	03630	ULTRASOUND	366,601		366,601	0
60.00	06000	LABORATORY	4,010,777		4,010,777	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	904,620	0	904,620	0
66.00	06600	PHYSICAL THERAPY	248,116	0	248,116	0
69.00	06900	ELECTROCARDIOLOGY	145,993		145,993	0
69.01	03140	CARDIAC CATH LAB	97,382		97,382	0
70.01	07001	SLEEP LAB	0		0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,417,974		1,417,974	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	701,918		701,918	0
73.00	07300	DRUGS CHARGED TO PATIENTS	7,897,956		7,897,956	0
74.00	07400	RENAL DIALYSIS	153,379		153,379	0
75.00	07500	ASC (NON-DISTINCT PART)	909,973		909,973	0
75.01	03480	ONCOLOGY	989,901		989,901	0
75.02	03340	GI LAB	110,812		110,812	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,594,470		2,594,470	0
90.01	09001	WOUND CARE CENTER	75,998		75,998	0
91.00	09100	EMERGENCY	3,500,856		3,500,856	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	532,375		532,375	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	45,652,587	0	45,652,587	0
201.00		Less Observation Beds	532,375		532,375	0
202.00		Total (see instructions)	45,120,212	0	45,120,212	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	0.000000	69.01
70.01	07001	SLEEP LAB	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	03480	ONCOLOGY	0	0	0	0.000000	75.01
75.02	03340	GI LAB	0	0	0	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	0	0	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03630	ULTRASOUND	0.000000			54.01
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	03140	CARDIAC CATH LAB	0.000000			69.01
70.01	07001	SLEEP LAB	0.000000			70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03480	ONCOLOGY	0.000000			75.01
75.02	03340	GI LAB	0.000000			75.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CARE CENTER	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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		999,443	0	999,443	21,030	47.52	30.00
31.00	INTENSIVE CARE UNIT		68,940		68,940	389	177.22	31.00
200.00	Total (lines 30 through 199)		1,068,383		1,068,383	21,419		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		4,862	231,042				
31.00	INTENSIVE CARE UNIT		135	23,925				
200.00	Total (lines 30 through 199)		4,997	254,967	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/26/2021 8:21 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	158,050	2,206,953	0.071615	190,186	13,620	50.00
53.00	05300	ANESTHESIOLOGY	9,144	1,193,507	0.007661	63,978	490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,061	12,758,673	0.014661	1,027,532	15,065	54.00
54.01	03630	ULTRASOUND	9,211	2,229,609	0.004131	194,447	803	54.01
60.00	06000	LABORATORY	134,927	18,033,024	0.007482	3,286,624	24,591	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	66,850	8,254,682	0.008098	2,279,574	18,460	65.00
66.00	06600	PHYSICAL THERAPY	50,850	67,418	0.754250	12,406	9,357	66.00
69.00	06900	ELECTROCARDIOLOGY	5,454	2,321,062	0.002350	296,078	696	69.00
69.01	03140	CARDIAC CATH LAB	30,252	152,668	0.198155	1,720	341	69.01
70.01	07001	SLEEP LAB	0	0	0.000000	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,770	5,666,979	0.018664	956,217	17,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,358	2,805,237	0.018664	339,987	6,346	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,875	34,055,754	0.001817	3,437,668	6,246	73.00
74.00	07400	RENAL DIALYSIS	2,060	364,816	0.005647	103,516	585	74.00
75.00	07500	ASC (NON-DISTINCT PART)	163,149	1,774,599	0.091936	46,799	4,303	75.00
75.01	03480	ONCOLOGY	95,356	5,017,977	0.019003	16,303	310	75.01
75.02	03340	GI LAB	35,909	2,145,728	0.016735	214	4	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	129,153	4,294,797	0.030072	2,372	71	90.00
90.01	09001	WOUND CARE CENTER	16,850	244,677	0.068866	643	44	90.01
91.00	09100	EMERGENCY	87,293	5,810,310	0.015024	711,131	10,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,780	1,673,706	0.023170	0	0	92.00
200.00		Total (lines 50 through 199)	1,440,352	111,072,176		12,967,395	129,863	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/26/2021 8:21 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
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	21,030	0.00	4,862			30.00	
31.00	03100	INTENSIVE CARE UNIT		0	389	0.00	135			31.00	
200.00		Total (lines 30 through 199)		0	21,419		4,997			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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/26/2021 8:21 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	0	54.01
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
69.01	03140	CARDIAC CATH LAB	0	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03480	ONCOLOGY	0	0	0	0	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/26/2021 8:21 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	2,206,953	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,193,507	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,758,673	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	2,229,609	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	18,033,024	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	8,254,682	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	67,418	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,321,062	0.000000	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	152,668	0.000000	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,666,979	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,805,237	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,055,754	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	364,816	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	1,774,599	0.000000	75.00
75.01	03480	ONCOLOGY	0	0	0	5,017,977	0.000000	75.01
75.02	03340	GI LAB	0	0	0	2,145,728	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	4,294,797	0.000000	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	244,677	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	5,810,310	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,673,706	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	111,072,176		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/26/2021 8:21 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	190,186	0	225,424	0	50.00	
53.00	05300 ANESTHESIOLOGY	0.000000	63,978	0	88,162	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,027,532	0	1,785,124	0	54.00	
54.01	03630 ULTRASOUND	0.000000	194,447	0	188,456	0	54.01	
60.00	06000 LABORATORY	0.000000	3,286,624	0	865,329	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	2,279,574	0	106,531	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	12,406	0	29	0	66.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	296,078	0	265,516	0	69.00	
69.01	03140 CARDIAC CATH LAB	0.000000	1,720	0	29,597	0	69.01	
70.01	07001 SLEEP LAB	0.000000	0	0	0	0	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	956,217	0	345,868	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	339,987	0	237,151	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	3,437,668	0	7,019,848	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	103,516	0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	46,799	0	68,230	0	75.00	
75.01	03480 ONCOLOGY	0.000000	16,303	0	984,899	0	75.01	
75.02	03340 GI LAB	0.000000	214	0	108,527	0	75.02	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	2,372	0	763,295	0	90.00	
90.01	09001 WOUND CARE CENTER	0.000000	643	0	20,904	0	90.01	
91.00	09100 EMERGENCY	0.000000	711,131	0	329,286	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	157,940	0	92.00	
200.00	Total (lines 50 through 199)		12,967,395	0	13,590,116	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/26/2021 8:21 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	1.231164	225,424	4	19	277,534	50.00
53.00	05300	ANESTHESIOLOGY	0.557132	88,162	0	0	49,118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231476	1,785,124	0	1	413,213	54.00
54.01	03630	ULTRASOUND	0.164424	188,456	0	0	30,987	54.01
60.00	06000	LABORATORY	0.222413	865,329	4,914	0	192,460	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.109589	106,531	0	0	11,675	65.00
66.00	06600	PHYSICAL THERAPY	3.680263	29	0	0	107	66.00
69.00	06900	ELECTROCARDIOLOGY	0.062899	265,516	0	0	16,701	69.00
69.01	03140	CARDIAC CATH LAB	0.637868	29,597	0	0	18,879	69.01
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250217	345,868	0	1	86,542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250217	237,151	10,770	0	59,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231913	7,019,848	3,243	14,960	1,627,994	73.00
74.00	07400	RENAL DIALYSIS	0.420428	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.512777	68,230	0	0	34,987	75.00
75.01	03480	ONCOLOGY	0.197271	984,899	0	136	194,292	75.01
75.02	03340	GI LAB	0.051643	108,527	0	0	5,605	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.604096	763,295	0	535	461,103	90.00
90.01	09001	WOUND CARE CENTER	0.310605	20,904	0	0	6,493	90.01
91.00	09100	EMERGENCY	0.602525	329,286	0	25	198,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.318082	157,940	0	0	50,238	92.00
200.00		Subtotal (see instructions)		13,590,116	18,931	15,677	3,735,670	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		13,590,116	18,931	15,677	3,735,670	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/26/2021 8:21 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		5	23				
53.00	05300	ANESTHESIOLOGY		0	0				
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0				
54.01	03630	ULTRASOUND		0	0				
60.00	06000	LABORATORY		1,093	0				
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0				
65.00	06500	RESPIRATORY THERAPY		0	0				
66.00	06600	PHYSICAL THERAPY		0	0				
69.00	06900	ELECTROCARDIOLOGY		0	0				
69.01	03140	CARDIAC CATH LAB		0	0				
70.01	07001	SLEEP LAB		0	0				
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0				
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		2,695	0				
73.00	07300	DRUGS CHARGED TO PATIENTS		752	3,469				
74.00	07400	RENAL DIALYSIS		0	0				
75.00	07500	ASC (NON-DISTINCT PART)		0	0				
75.01	03480	ONCOLOGY		0	27				
75.02	03340	GI LAB		0	0				
76.97	07697	CARDIAC REHABILITATION		0	0				
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0				
76.99	07699	LITHOTRIPSY		0	0				
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	323				
90.01	09001	WOUND CARE CENTER		0	0				
91.00	09100	EMERGENCY		0	15				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0				
200.00		Subtotal (see instructions)		4,545	3,857				
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0					
202.00		Net Charges (line 200 - line 201)		4,545	3,857				

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital 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		999,443	0	999,443	21,030	47.52	30.00
31.00	INTENSIVE CARE UNIT		68,940		68,940	389	177.22	31.00
200.00	Total (lines 30 through 199)		1,068,383		1,068,383	21,419		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,168	55,503				
31.00	INTENSIVE CARE UNIT		0	0				
200.00	Total (lines 30 through 199)		1,168	55,503	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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	158,050	0	0.000000	70,028	0 50.00
53.00	05300	ANESTHESIOLOGY	9,144	0	0.000000	9,903	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,061	0	0.000000	249,868	0 54.00
54.01	03630	ULTRASOUND	9,211	0	0.000000	43,966	0 54.01
60.00	06000	LABORATORY	134,927	0	0.000000	555,843	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	66,850	0	0.000000	779,153	0 65.00
66.00	06600	PHYSICAL THERAPY	50,850	0	0.000000	1,939	0 66.00
69.00	06900	ELECTROCARDIOLOGY	5,454	0	0.000000	73,206	0 69.00
69.01	03140	CARDIAC CATH LAB	30,252	0	0.000000	0	0 69.01
70.01	07001	SLEEP LAB	0	0	0.000000	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,770	0	0.000000	10,325	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,358	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,875	0	0.000000	548,991	0 73.00
74.00	07400	RENAL DIALYSIS	2,060	0	0.000000	21,996	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	163,149	0	0.000000	5,115	0 75.00
75.01	03480	ONCOLOGY	95,356	0	0.000000	8,691	0 75.01
75.02	03340	GI LAB	35,909	0	0.000000	11,652	0 75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	129,153	0	0.000000	775	0 90.00
90.01	09001	WOUND CARE CENTER	16,850	0	0.000000	0	0 90.01
91.00	09100	EMERGENCY	87,293	0	0.000000	160,771	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	38,780	0	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	1,440,352	0		2,552,222	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0115		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/26/2021 8:21 pm		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
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	21,030	0.00	1,168	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	389	0.00	0	0	0	31.00	
200.00		Total (lines 30 through 199)		0	21,419		1,168			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
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0115

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	0	54.01
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
69.01	03140	CARDIAC CATH LAB	0	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0	70.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03480	ONCOLOGY	0	0	0	0	0	75.01
75.02	03340	GI LAB	0	0	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description			Title XIX		Hospital		Cost	
			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	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	0	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	0	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	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03140	CARDIAC CATH LAB	0	0	0	0	0.000000	69.01
70.01	07001	SLEEP LAB	0	0	0	0	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	03480	ONCOLOGY	0	0	0	0	0.000000	75.01
75.02	03340	GI LAB	0	0	0	0	0.000000	75.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE CENTER	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Title XIX			Hospital		Cost	
		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	70,028	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,903	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	249,868	0	0	0	54.00
54.01	03630	ULTRASOUND	0.000000	43,966	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	555,843	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	779,153	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,939	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	73,206	0	0	0	69.00
69.01	03140	CARDIAC CATH LAB	0.000000	0	0	0	0	69.01
70.01	07001	SLEEP LAB	0.000000	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,325	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	548,991	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	21,996	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	5,115	0	0	0	75.00
75.01	03480	ONCOLOGY	0.000000	8,691	0	0	0	75.01
75.02	03340	GI LAB	0.000000	11,652	0	0	0	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	775	0	0	0	90.00
90.01	09001	WOUND CARE CENTER	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	160,771	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)		2,552,222	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/26/2021 8:21 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)		21,030	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,030	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)		20,214	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)		4,862	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)		13,720,307	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)		13,720,307	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)		13,720,307	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)		652.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,172,066	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)		3,172,066	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	937,786	389	2,410.76	135	325,453
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)					3,208,221
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,705,740
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					254,967
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					129,863
52.00	Total Program excludable cost (sum of lines 50 and 51)					384,830
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,320,910
	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)					816
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					652.42
89.00	Observation bed cost (line 87 x line 88) (see instructions)					532,375

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 8:21 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	999,443	13,720,307	0.072844	532,375	38,780	90.00
91.00 Nursing School cost	0	13,720,307	0.000000	532,375	0	91.00
92.00 Allied health cost	0	13,720,307	0.000000	532,375	0	92.00
93.00 All other Medical Education	0	13,720,307	0.000000	532,375	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/26/2021 8:21 pm
Title XIX		Hospital	Cost	
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)	21,030	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,030	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)	20,214	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,168	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)	13,720,307	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)	13,720,307	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)	13,720,307	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)	652.42	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	762,027	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)	762,027	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	937,786	389	2,410.76	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					762,027	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					816	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					652.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					532,375	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0115

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

Worksheet D-1

Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	999,443	13,720,307	0.072844	532,375	38,780	90.00
91.00	Nursing School cost	0	13,720,307	0.000000	532,375	0	91.00
92.00	Allied health cost	0	13,720,307	0.000000	532,375	0	92.00
93.00	All other Medical Education	0	13,720,307	0.000000	532,375	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/26/2021 8:21 pm
Cost Center Description			Title XVIII	Hospital	PPS
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,398,150	30.00
31.00	03100	INTENSIVE CARE UNIT		369,876	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.231164	190,186	50.00
53.00	05300	ANESTHESIOLOGY	0.557132	63,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231476	1,027,532	54.00
54.01	03630	ULTRASOUND	0.164424	194,447	54.01
60.00	06000	LABORATORY	0.222413	3,286,624	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.109589	2,279,574	65.00
66.00	06600	PHYSICAL THERAPY	3.680263	12,406	66.00
69.00	06900	ELECTROCARDIOLOGY	0.062899	296,078	69.00
69.01	03140	CARDIAC CATH LAB	0.637868	1,720	69.01
70.01	07001	SLEEP LAB	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.250217	956,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.250217	339,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.231913	3,437,668	73.00
74.00	07400	RENAL DIALYSIS	0.420428	103,516	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.512777	46,799	75.00
75.01	03480	ONCOLOGY	0.197271	16,303	75.01
75.02	03340	GI LAB	0.051643	214	75.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.604096	2,372	90.00
90.01	09001	WOUND CARE CENTER	0.310605	643	90.01
91.00	09100	EMERGENCY	0.602525	711,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.318082	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,967,395	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)		12,967,395	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/26/2021 8:21 pm	
		Title XIX	Hospital	Cost	
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		1,614,270		30.00
31.00	03100 INTENSIVE CARE UNIT		69,382		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000	70,028	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	9,903	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	249,868	0	54.00
54.01	03630 ULTRASOUND	0.000000	43,966	0	54.01
60.00	06000 LABORATORY	0.000000	555,843	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	779,153	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,939	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	73,206	0	69.00
69.01	03140 CARDIAC CATH LAB	0.000000	0	0	69.01
70.01	07001 SLEEP LAB	0.000000	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	10,325	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	548,991	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	21,996	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	5,115	0	75.00
75.01	03480 ONCOLOGY	0.000000	8,691	0	75.01
75.02	03340 GI LAB	0.000000	11,652	0	75.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	775	0	90.00
90.01	09001 WOUND CARE CENTER	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.000000	160,771	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,552,222	0	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)		2,552,222		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/26/2021 8:21 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,943,953	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,810,366	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)		75,883	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		28,382	2.04
3.00	Managed Care Simulated Payments		2,933,094	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		153.67	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		15.64	30.00
31.00	Percentage of Medicaid patient days (see instructions)		52.48	31.00
32.00	Sum of lines 30 and 31		68.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)		45.41	33.00
34.00	Disproportionate share adjustment (see instructions)		880,309	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/26/2021 8:21 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	592,492	405,398		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	148,932	303,215		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	452,147			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	9,191,040			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)		9,191,040		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		698,882		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,889,922		59.00
60.00	Primary payer payments		4,804		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,885,118		61.00
62.00	Deductibles billed to program beneficiaries		684,068		62.00
63.00	Coinsurance billed to program beneficiaries		149,774		63.00
64.00	Allowable bad debts (see instructions)		635,862		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		413,310		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		547,960		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,464,586		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		12,881		70.93
70.94	HRR adjustment amount (see instructions)		-4,846		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/26/2021 8:21 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		26,090	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,446,531	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		10,987,846	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)		-1,541,315	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		394,332	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2021 8:21 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,943,953	0	1,943,953		1,943,953
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,810,366	0		5,810,366	5,810,366
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	75,883	0	0		75,883
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	28,382	0		28,382	28,382
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	2,933,094	0	0	2,933,094	2,933,094
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4541	0.4541	0.4541	0.4541	
11.00	Disproportionate share adjustment (see instructions)	34.00	880,309	0	220,687	659,622	880,309
11.01	Uncompensated care payments	36.00	452,147	0	148,932	303,215	452,147
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	9,191,040	0	2,313,572	6,877,468	9,191,040
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,191,040	0	2,313,572	6,877,468	9,191,040
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	698,882	0	176,156	522,726	698,882

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2021 8:21 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	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	2,489,728	7,400,194	9,889,922
		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	601,783	0	151,682	450,101	601,783
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	8,095	0	2,040	6,055	8,095
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1479	0.1479	0.1479	0.1479	
25.00	Disproportionate share adjustment (see instructions)	11.00	89,004	0	22,434	66,570	89,004
26.00	Total prospective capital payments (see instructions)	12.00	698,882	0	176,156	522,726	698,882
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2021 8:21 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	1,943,953	1,943,953		1,943,953
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,810,366		5,810,366	5,810,366
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
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
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	75,883	75,883		75,883
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	28,382		28,382	28,382
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	2,933,094	582,444	2,350,650	2,933,094
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4541	0.4541	0.4541	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	880,309	220,687	659,622	880,309
11.01	Uncompensated care payments	36.00	452,147	148,932	303,215	452,147
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	9,191,040	2,389,455	6,801,585	9,191,040
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,191,040	2,389,455	6,801,585	9,191,040
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	698,882	182,430	516,452	698,882
17.00	Special add-on payments for new technologies	54.00	0	0	0	0
17.01	Net organ acquisition cost					
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	SUBTOTAL			2,571,885	7,318,037	9,889,922

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2021 8:21 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	601,783	153,762	448,021	601,783	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	8,095	5,927	2,168	8,095	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1479	0.1479	0.1479		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	89,004	22,741	66,263	89,004	25.00
26.00	Total prospective capital payments (see instructions)	12.00	698,882	182,430	516,452	698,882	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	12,881	29,272	-16,391	12,881	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	-4,846	7,866	-12,712	-4,846	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		26,090	0	26,090	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/26/2021 8:21 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,402	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,735,670	2.00
3.00	OPPS payments		3,229,266	3.00
4.00	Outlier payment (see instructions)		15,940	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.820	5.00
6.00	Line 2 times line 5		3,063,249	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)		8,402	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		34,608	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)		34,608	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)		34,608	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		26,206	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)		8,402	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)		3,245,206	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		2,154	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		674,674	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)		2,576,780	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)		2,576,780	30.00
31.00	Primary payer payments		297	31.00
32.00	Subtotal (line 30 minus line 31)		2,576,483	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)		205,978	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		133,886	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		103,041	36.00
37.00	Subtotal (see instructions)		2,710,369	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)		2,710,369	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		2,728,816	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)		-18,447	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/26/2021 8:21 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,708,327		2,834,353	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	05/27/2021	279,519		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
3.10			0		0	3.10
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0	05/27/2021	105,537	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)		279,519		-105,537	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,987,846		2,728,816	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,541,315		18,447	6.02
7.00	Total Medicare program liability (see instructions)		9,446,531		2,710,369	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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/26/2021 8:21 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2021 8:21 pm	
		Title XIX	Hospital	Cost	
			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	762,027			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)	762,027		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)	762,027		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	2,277,531			8.00
9.00	Ancillary service charges	2,552,222		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)	4,829,753		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)	4,829,753		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	4,067,726		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)	762,027		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)	762,027		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)	762,027		0	31.00
32.00	Deductibles	0			32.00
33.00	Coinurance	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)	762,027		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	762,027		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)	762,027		0	40.00
41.00	Interim payments	771,184		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-9,157			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

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

Provider CCN: 14-0115

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

Worksheet G

Date/Time Prepared:
11/26/2021 8:21 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	12,802,164	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	12,771,426	0	0	0	4.00
5.00 Other receivable	11,779,935	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-8,091,574	0	0	0	6.00
7.00 Inventory	2,070,879	0	0	0	7.00
8.00 Prepaid expenses	358,267	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)	31,691,097	0	0	0	11.00
FIXED ASSETS					
12.00 Land	14,137,215	0	0	0	12.00
13.00 Land improvements	1,628,949	0	0	0	13.00
14.00 Accumulated depreciation	-1,567,764	0	0	0	14.00
15.00 Buildings	40,791,751	0	0	0	15.00
16.00 Accumulated depreciation	-45,042,835	0	0	0	16.00
17.00 Leasehold improvements	29,671,426	0	0	0	17.00
18.00 Accumulated depreciation	-35,249	0	0	0	18.00
19.00 Fixed equipment	14,308,932	0	0	0	19.00
20.00 Accumulated depreciation	-7,981,726	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	28,128,213	0	0	0	23.00
24.00 Accumulated depreciation	-26,437,154	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)	47,601,758	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	411,796,461	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	3,796,954	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	415,593,415	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	494,886,270	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	-5,718,262	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,874,864	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	16,423,554	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	12,580,156	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	9,283,871	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	9,283,871	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	21,864,027	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	473,022,243				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)	473,022,243	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	494,886,270	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0115

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

Worksheet G-1

Date/Time Prepared:
11/26/2021 8:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		358,374,180		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		104,559,132				2.00
3.00	Total (sum of line 1 and line 2)		462,933,312		0		3.00
4.00	RECONCILING ITEM	10,088,932		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		10,088,932		0		10.00
11.00	Subtotal (line 3 plus line 10)		473,022,244		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		473,022,243		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	RECONCILING ITEM		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		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: 14-0115

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2021 8:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	31,116,615		31,116,615	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	31,116,615		31,116,615	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,173,114		1,173,114	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)	1,173,114		1,173,114	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	32,289,729		32,289,729	17.00
18.00	Ancillary services	39,378,973	59,669,713	99,048,686	18.00
19.00	Outpatient services	2,837,496	9,185,994	12,023,490	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
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	7,390,944	7,390,944	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	74,506,198	76,246,651	150,752,849	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,917,327		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		63,917,327		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0115

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

Worksheet G-3

Date/Time Prepared:
11/26/2021 8:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	150,752,849	1.00
2.00	Less contractual allowances and discounts on patients' accounts	102,178,131	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,574,718	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,917,327	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-15,342,609	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	7,266,199	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	4,904	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	79,745	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	2,111	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	964,809	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENT	74,925,533	24.00
24.01	MEANINGFUL USE REVENUE INCL ACCRUAL	0	24.01
24.02	GAIN ON INVESTMENT	9,217,878	24.02
24.03	MISC OPERATING REVENUE	11,101,711	24.03
24.04	PROVIDER TAX REV	17,063,517	24.04
24.05	NON OPERATING EXPENSES	0	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	120,626,407	25.00
26.00	Total (line 5 plus line 25)	105,283,798	26.00
27.00	NON OPERATING EXPENSE	724,666	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	724,666	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	104,559,132	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0115	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/26/2021 8:21 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		601,783	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		8,095	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)		56.45	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		15.64	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		52.48	8.00
9.00	Sum of lines 7 and 8		68.12	9.00
10.00	Allowable disproportionate share percentage (see instructions)		14.79	10.00
11.00	Disproportionate share adjustment (see instructions)		89,004	11.00
12.00	Total prospective capital payments (see instructions)		698,882	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