

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: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/22/2022 5:15 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/22/2022	Time: 5:15 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEKIN MEMORIAL HOSPITAL (14-0120) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	65,484	-75,839	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	65,484	-75,839	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 5:15 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 600 SOUTH 13TH STREET			PO Box:				1.00	
2.00	City: PEKIN			State: IL		Zip Code: 61554		County: TAZEWELL	
		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N
4.00	Subprovider - IPF							P	N
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
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		

Worksheet S-2
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 5:15 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		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
						0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 5:15 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	955,608	0	2,410118.01
		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	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 5:15 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: PEORIA HOME OFFICE		Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC		Contractor's Number: 00131				141.00
142.00	Street: 221 NE GLEN OAK		PO Box:						142.00
143.00	City: PEORIA		State: IL		Zip Code: 61636				143.00
									1.00
144.00 Are provider based physicians' costs included in Worksheet A?									Y
									1.00
									2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.								145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N		149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
									1.00
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
									1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00		169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/22/2022 5:15 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	04/11/2022	Y	04/11/2022
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		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.	KEITH	LYONS		41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITY POINT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-712-1132	JONATHAN.LYONS@UNITYPOINT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/22/2022 5:15 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT ANALYST		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: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	41	14,965	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)		41	14,965	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		45	16,425	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	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		45			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,044	941	7,435			1.00
2.00	HMO and other (see instructions)	2,634	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,044	941	7,435			7.00
8.00	INTENSIVE CARE UNIT	345	75	809			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	3,389	1,016	8,244	0.00	253.10	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	253.10	27.00
28.00	Observation Bed Days		325	2,382			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			13			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: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	702	217	1,606	1.00
2.00 HMO and other (see instructions)			434	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	702	217	1,606	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	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	14,582,787	0	14,582,787	510,534.00	28.56
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	164,370	164,370	9,073.00	18.12
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,284,785	0	1,284,785	22,408.00	57.34
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		3,505,379	0	3,505,379	96,790.00	36.22
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)		6,147,268	0	6,147,268		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		849,192	0	849,192		
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: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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	277,140	0	277,140	11,463.00	24.18	26.00
27.00	Administrative & General	5.00	187,819	0	187,819	5,690.00	33.01	27.00
28.00	Administrative & General under contract (see inst.)		159,955	0	159,955	441.00	362.71	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	482,477	0	482,477	17,489.00	27.59	30.00
31.00	Laundry & Linen Service	8.00	33,868	0	33,868	2,084.00	16.25	31.00
32.00	Housekeeping	9.00	636,872	0	636,872	37,895.00	16.81	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	743,242	-603,917	139,325	7,691.00	18.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	439,547	439,547	24,262.00	18.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	430	0	430	20.00	21.50	38.00
39.00	Central Services and Supply	14.00	339,504	0	339,504	17,616.00	19.27	39.00
40.00	Pharmacy	15.00	708,386	0	708,386	16,832.00	42.09	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/22/2022 5:15 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	14,742,742	0	14,742,742	510,975.00	28.85	1.00
2.00	Excluded area salaries (see instructions)	0	164,370	164,370	9,073.00	18.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)	14,742,742	-164,370	14,578,372	501,902.00	29.05	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,790,164	0	4,790,164	119,198.00	40.19	4.00
5.00	Subtotal wage-related costs (see inst.)	6,996,460	0	6,996,460	0.00	47.99	5.00
6.00	Total (sum of lines 3 thru 5)	26,529,366	-164,370	26,364,996	621,100.00	42.45	6.00
7.00	Total overhead cost (see instructions)	3,569,693	-164,370	3,405,323	141,483.00	24.07	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/22/2022 5:15 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	575,797	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)	2,450,518	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)	1,889,485	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	60,231	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	6,504	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	96,909	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	1,044,695	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	5,005	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	18,122	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,147,266	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/22/2022 5:15 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.131683		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,500,229		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		81,489,904		6.00
7.00	Medicaid cost (line 1 times line 6)		10,730,835		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)		3,230,606		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)		3,230,606		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)	1,799,487	951,967	2,751,454	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	236,962	951,967	1,188,929	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)	236,962	951,967	1,188,929	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)		3,735,804		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		28,137		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		43,287		27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,692,517		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		501,392		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,690,321		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,920,927		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0120

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

Worksheet A

Date/Time Prepared:
5/22/2022 5:15 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	-156,024	-156,024	536,094	380,070	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	82,376	82,376	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	277,140	615,091	892,231	892,231	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	187,819	5,868,756	6,056,575	5,948,720	5.00
7.00	00700	OPERATION OF PLANT	482,477	2,355,085	2,837,562	-361	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,868	11,110	44,978	44,978	8.00
9.00	00900	HOUSEKEEPING	636,872	440,486	1,077,358	-9,266	9.00
10.00	01000	DIETARY	743,242	535,055	1,278,297	-1,047,453	10.00
11.00	01100	CAFETERIA	0	0	755,974	755,974	11.00
13.00	01300	NURSING ADMINISTRATION	430	292	722	722	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	339,504	467,747	807,251	-18,007	14.00
15.00	01500	PHARMACY	708,386	2,158,748	2,867,134	-1,851,721	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,714,087	2,270,273	4,984,360	-1,464,707	30.00
31.00	03100	INTENSIVE CARE UNIT	628,665	377,137	1,005,802	436,443	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,054,707	4,469,016	6,523,723	-3,150,248	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	201,289	201,289	-197,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,449,926	701,014	2,150,940	28,731	54.00
56.00	05600	RADIOISOTOPE	117,689	303,544	421,233	-420,073	56.00
57.00	05700	CT SCAN	402,847	350,236	753,083	-144,775	57.00
58.00	05800	MRI	177,967	354,753	532,720	-37,966	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,214	161,645	165,859	-5,247	59.00
60.00	06000	LABORATORY	716,611	1,783,685	2,500,296	-197,436	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	193,977	63.00
64.00	06400	INTRAVENOUS THERAPY	116,345	39,020	155,365	1,210,078	64.00
65.00	06500	RESPIRATORY THERAPY	389,845	217,260	607,105	-57,295	65.00
66.00	06600	PHYSICAL THERAPY	0	902,089	902,089	-251,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	76,765	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	174,334	68.00
69.00	06900	ELECTROCARDIOLOGY	207,702	78,940	286,642	-15,591	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	37,177	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,237,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,126,039	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,153,796	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	107,376	123,360	230,736	-230,736	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	156,152	62,332	218,484	167,650	90.00
91.00	09100	EMERGENCY	1,928,916	2,181,497	4,110,413	-780,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				3,330,356	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		529,655	529,655	-512,252	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,582,787	27,403,091	41,985,878	-282,699	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	282,699	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	14,582,787	27,403,091	41,985,878	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0120

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

Worksheet A

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-47,168	332,902	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	82,376	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-792,080	100,151	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,478,385	11,427,105	5.00
7.00	00700	OPERATION OF PLANT	328,424	3,165,625	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,380	48,358	8.00
9.00	00900	HOUSEKEEPING	-19,651	1,048,441	9.00
10.00	01000	DIETARY	-742	230,102	10.00
11.00	01100	CAFETERIA	-250,615	505,359	11.00
13.00	01300	NURSING ADMINISTRATION	653,742	654,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,191	791,435	14.00
15.00	01500	PHARMACY	6,507	1,021,920	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	587,745	587,745	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,449	3,517,204	30.00
31.00	03100	INTENSIVE CARE UNIT	-23,860	1,418,385	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	111,153	3,484,628	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-3,532	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,464	2,185,135	54.00
56.00	05600	RADIOISOTOPE	-6,919	-5,759	56.00
57.00	05700	CT SCAN	54,664	662,972	57.00
58.00	05800	MRI	-28,486	466,268	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,570	201,182	59.00
60.00	06000	LABORATORY	-65,890	2,236,970	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	193,977	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,365,443	64.00
65.00	06500	RESPIRATORY THERAPY	622	550,432	65.00
66.00	06600	PHYSICAL THERAPY	0	650,929	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	76,765	67.00
68.00	06800	SPEECH PATHOLOGY	0	174,334	68.00
69.00	06900	ELECTROCARDIOLOGY	6,196	277,247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	37,177	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,237,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,126,039	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,153,796	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03610	SLEEP LAB	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-4,700	381,434	90.00
91.00	09100	EMERGENCY	-1,020,659	2,309,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-17,403	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,994,889	46,698,068	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	282,699	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	VACANT SPACE	0	0	194.00
194.01	07951	LEASED SPACE	0	0	194.01
194.02	07952	FOUNDATION	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	4,994,889	46,980,767	200.00

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet A-6
Date/Time Prepared:
5/22/2022 5:15 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	439,547	316,427		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	164,370	118,329		2.00
			603,917	434,756		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,237,830		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
			0	2,237,830		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,153,796		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
			0	2,153,796		
	G - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,126,039		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
			0	2,126,039		
	H - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	193,977		1.00
			0	193,977		

RECLASSIFICATIONS

Provider CCN: 14-0120

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

Worksheet A-6

Date/Time Prepared:
5/22/2022 5:15 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	512,252	1.00
	0		0	512,252	
J - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,842	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	82,376	2.00
	TOTALS		0	106,218	
K - COST CENTER MAPPING					
1.00	INTENSIVE CARE UNIT	31.00	312,424	191,267	1.00
2.00	OPERATING ROOM	50.00	98,296	40,585	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	117,218	168,058	3.00
4.00	LABORATORY	60.00	5,236	1,277	4.00
5.00	INTRAVENOUS THERAPY	64.00	685,200	541,880	5.00
6.00	RESPIRATORY THERAPY	65.00	21,121	12,657	6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	76,765	7.00
8.00	SPEECH PATHOLOGY	68.00	0	174,334	8.00
9.00	ELECTROENCEPHALOGRAPHY	70.00	3,400	33,777	9.00
10.00	CLINIC	90.00	128,272	48,175	10.00
11.00		0.00	0	0	11.00
	0		1,371,167	1,288,775	
N - TO RECLASS ANESTHESIOLOGY EXPENSE					
1.00	OPERATING ROOM	50.00	0	114,780	1.00
	0		0	114,780	
500.00	Grand Total: Increases		1,975,084	9,168,423	500.00

RECLASSIFICATIONS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet A-6
Date/Time Prepared:
5/22/2022 5:15 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	603,917	434,756	0		1.00
2.00		0.00	0	0	0		2.00
	0		603,917	434,756			
	E - TO RECLASS SUPPLY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,637	0		1.00
2.00	OPERATION OF PLANT	7.00	0	361	0		2.00
3.00	HOUSEKEEPING	9.00	0	9,266	0		3.00
4.00	DIETARY	10.00	0	6,673	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,626	0		5.00
6.00	PHARMACY	15.00	0	6,125	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	229,463	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	255	0		8.00
9.00	OPERATING ROOM	50.00	0	1,350,164	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	48,496	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,892	0		11.00
12.00	RADIOISOTOPE	56.00	0	132,577	0		12.00
13.00	CT SCAN	57.00	0	118,209	0		13.00
14.00	MRI	58.00	0	11,148	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	2,590	0		15.00
16.00	LABORATORY	60.00	0	9,921	0		16.00
17.00	INTRAVENOUS THERAPY	64.00	0	2,557	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	60	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	3,537	0		19.00
20.00	SLEEP LAB	76.00	0	23,181	0		20.00
21.00	CLINIC	90.00	0	1,545	0		21.00
22.00	EMERGENCY	91.00	0	121,631	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	78,916	0		23.00
	0		0	2,237,830			
	F - TO RECLASS BILLABLE DRUGS						
1.00	DIETARY	10.00	0	2,107	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	293	0		2.00
3.00	PHARMACY	15.00	0	1,845,596	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	57,957	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	145	0		5.00
6.00	OPERATING ROOM	50.00	0	44,414	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	33,218	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,949	0		8.00
9.00	RADIOISOTOPE	56.00	0	1,064	0		9.00
10.00	CT SCAN	57.00	0	23,301	0		10.00
11.00	MRI	58.00	0	25,245	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	2,332	0		12.00
13.00	LABORATORY	60.00	0	51	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	5,727	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	5,412	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	6,762	0		16.00
17.00	SLEEP LAB	76.00	0	6,728	0		17.00
18.00	CLINIC	90.00	0	29	0		18.00
19.00	EMERGENCY	91.00	0	90,466	0		19.00
	0		0	2,153,796			
	G - IMPLANTIBLES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,088	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14,218	0		2.00
3.00	OPERATING ROOM	50.00	0	2,009,331	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	1,263	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,283	0		5.00
6.00	RADIOISOTOPE	56.00	0	1,156	0		6.00
7.00	CT SCAN	57.00	0	3,265	0		7.00
8.00	MRI	58.00	0	1,573	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	325	0		9.00
10.00	INTRAVENOUS THERAPY	64.00	0	2,205	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	788	0		11.00
12.00	SLEEP LAB	76.00	0	37,449	0		12.00
13.00	EMERGENCY	91.00	0	44,095	0		13.00
	0		0	2,126,039			
	H - BLOOD						
1.00	LABORATORY	60.00	0	193,977	0		1.00
	0		0	193,977			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	512,252	11		1.00
	0		0	512,252			

RECLASSIFICATIONS

Provider CCN: 14-0120

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

Worksheet A-6

Date/Time Prepared:
5/22/2022 5:15 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
J - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	106,218	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	106,218		
K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	703,995	459,074	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	41,799	25,049	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	130,224	51,197	0	3.00
4.00	RADIOISOTOPE	56.00	117,218	168,058	0	4.00
5.00	INTRAVENOUS THERAPY	64.00	5,236	1,277	0	5.00
6.00	RESPIRATORY THERAPY	65.00	5,030	1,715	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	251,100	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	3,400	1,104	0	8.00
9.00	SLEEP LAB	76.00	96,209	67,169	0	9.00
10.00	CLINIC	90.00	5,025	2,198	0	10.00
11.00	EMERGENCY	91.00	263,031	260,834	0	11.00
	0		1,371,167	1,288,775		
N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	114,780	0	1.00
	0		0	114,780		
500.00	Grand Total: Decreases		1,975,084	9,168,423		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,250,000	0	0	0	0	1.00	
2.00	Land Improvements	1,956,871	0	0	0	0	2.00	
3.00	Buildings and Fixtures	11,585,946	2,227,762	0	2,227,762	2,489,498	3.00	
4.00	Building Improvements	25,403,019	0	0	0	0	4.00	
5.00	Fixed Equipment	20,119,739	1,959	0	1,959	0	5.00	
6.00	Movable Equipment	37,762,066	1,516,213	0	1,516,213	152,407	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	99,077,641	3,745,934	0	3,745,934	2,641,905	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	99,077,641	3,745,934	0	3,745,934	2,641,905	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,250,000	0				1.00	
2.00	Land Improvements	1,956,871	0				2.00	
3.00	Buildings and Fixtures	11,324,210	0				3.00	
4.00	Building Improvements	25,403,019	0				4.00	
5.00	Fixed Equipment	20,121,698	0				5.00	
6.00	Movable Equipment	39,125,872	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	100,181,670	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	100,181,670	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-156,024	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)	-156,024	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	-156,024				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	-156,024				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,055,798	0	61,055,798	0.609451	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,125,872	0	39,125,872	0.390549	0	2.00
3.00	Total (sum of lines 1-2)	100,181,670	0	100,181,670	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	-156,024	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)	0	0	0	-156,024	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	465,084	23,842	0	0	332,902	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	82,376	0	0	82,376	2.00
3.00	Total (sum of lines 1-2)	465,084	106,218	0	0	415,278	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0120

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

Worksheet A-8

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,130,751			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	6,949,289			0	12.00
13.00	Laundry and linen service	B		0HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B		0CAFETERIA	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		0MEDICAL 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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	MOW & CATERING	B	-250,615	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0120

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

Worksheet A-8

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE	B	-100	OPERATION OF PLANT	7.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-19,644	HOUSEKEEPING	9.00	0	33.02
33.03	MISCELLANEOUS REVENUE	B	-836	CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04	MISCELLANEOUS REVENUE	B	-12,520	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	MISCELLANEOUS REVENUE	B	2,844	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-2,200	EMERGENCY	91.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	33.13
33.14	CRNA - PURCHASED SERVICES	A	0	ANESTHESIOLOGY	53.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-996,720	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	REMOVE NON-ALLOWABLE INTEREST	A	0	INTEREST EXPENSE	113.00	13	33.16
33.17	DEPRECIATION TO AHA	A	-47,168	CAP REL COSTS-BLDG & FIXT	1.00	11	33.17
33.18	DEPRECIATION TO AHA	A	286,344	OPERATION OF PLANT	7.00	0	33.18
33.19	DEPRECIATION TO AHA	A	3,380	LAUNDRY & LINEN SERVICE	8.00	0	33.19
33.20	DEPRECIATION TO AHA	A	-7	HOUSEKEEPING	9.00	0	33.20
33.21	DEPRECIATION TO AHA	A	-742	DIETARY	10.00	0	33.21
33.22	DEPRECIATION TO AHA	A	3,027	CENTRAL SERVICES & SUPPLY	14.00	0	33.22
33.23	DEPRECIATION TO AHA	A	6,507	PHARMACY	15.00	0	33.23
33.24	DEPRECIATION TO AHA	A	-648	ADULTS & PEDIATRICS	30.00	0	33.24
33.25	DEPRECIATION TO AHA	A	-20,600	INTENSIVE CARE UNIT	31.00	0	33.25
33.26	DEPRECIATION TO AHA	A	111,153	OPERATING ROOM	50.00	0	33.26
33.27	DEPRECIATION TO AHA	A	-3,532	ANESTHESIOLOGY	53.00	0	33.27
33.28	DEPRECIATION TO AHA	A	17,984	RADIOLOGY-DIAGNOSTIC	54.00	0	33.28
33.29	DEPRECIATION TO AHA	A	-6,919	RADIOISOTOPE	56.00	0	33.29
33.30	DEPRECIATION TO AHA	A	54,664	CT SCAN	57.00	0	33.30
33.31	DEPRECIATION TO AHA	A	-28,486	MRI	58.00	0	33.31
33.32	DEPRECIATION TO AHA	A	40,570	CARDIAC CATHETERIZATION	59.00	0	33.32
33.33	DEPRECIATION TO AHA	A	1,810	LABORATORY	60.00	0	33.33
33.34	DEPRECIATION TO AHA	A	1,018	RESPIRATORY THERAPY	65.00	0	33.34
33.35	DEPRECIATION TO AHA	A	3,352	ELECTROCARDIOLOGY	69.00	0	33.35
33.36	DEPRECIATION TO AHA	A	34,435	EMERGENCY	91.00	0	33.36
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		4,994,889				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: 14-0120

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

Worksheet A-8-1

Date/Time Prepared:
5/22/2022 5:15 pm

5/22/2022 5:15 pm						
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	PEORIA HOME OFFICE	204,640	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	PEORIA HOME OFFICE	587,745	0	2.00
3.00	13.00	NURSING ADMINISTRATION	PEORIA HOME OFFICE	653,742	0	3.00
4.00	7.00	OPERATION OF PLANT	PEORIA HOME OFFICE	42,180	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	PEORIA HOME OFFICE	5,478,385	0	4.01
4.02	113.00	INTEREST EXPENSE	PEORIA HOME OFFICE	504,211	521,614	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,470,903	521,614	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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	B		100.00	UNITY POINT	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: 14-0120

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

Worksheet A-8-1

Date/Time Prepared:
5/22/2022 5:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	204,640	9		1.00
2.00	587,745	0		2.00
3.00	653,742	0		3.00
4.00	42,180	0		4.00
4.01	5,478,385	0		4.01
4.02	-17,403	0		4.02
5.00	6,949,289			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	HEALTH SYSTEM		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: 14-0120

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

Worksheet A-8-2

Date/Time Prepared:
5/22/2022 5:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,801	1,801	0	246,400	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	3,260	3,260	0	246,400	0	2.00
3.00	60.00	LABORATORY	67,700	67,700	0	260,300	0	3.00
4.00	65.00	RESPIRATORY THERAPY	396	396	0	211,500	0	4.00
5.00	90.00	CLINIC	4,700	4,700	0	211,500	0	5.00
6.00	91.00	EMERGENCY	1,052,894	1,052,894	0	211,500	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,130,751	1,130,751	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,801		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	3,260		2.00
3.00	60.00	LABORATORY	0	0	0	67,700		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	396		4.00
5.00	90.00	CLINIC	0	0	0	4,700		5.00
6.00	91.00	EMERGENCY	0	0	0	1,052,894		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		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	0	0	1,130,751		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	332,902	332,902			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	82,376		82,376		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	100,151	6,668	0	106,819	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,427,105	9,835	1,680	1,403	11,440,023
7.00	00700	OPERATION OF PLANT	3,165,625	76,171	28,103	3,603	3,273,502
8.00	00800	LAUNDRY & LINEN SERVICE	48,358	6,271	383	253	55,265
9.00	00900	HOUSEKEEPING	1,048,441	9,164	161	4,756	1,062,522
10.00	01000	DIETARY	230,102	0	0	1,040	231,142
11.00	01100	CAFETERIA	505,359	0	0	3,283	508,642
13.00	01300	NURSING ADMINISTRATION	654,464	0	0	3	654,467
14.00	01400	CENTRAL SERVICES & SUPPLY	791,435	17,392	1,015	2,535	812,377
15.00	01500	PHARMACY	1,021,920	7,474	3,497	5,290	1,038,181
16.00	01600	MEDICAL RECORDS & LIBRARY	587,745	0	0	0	587,745
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,517,204	44,508	2,052	15,011	3,578,775
31.00	03100	INTENSIVE CARE UNIT	1,418,385	8,805	223	6,716	1,434,129
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,484,628	44,616	14,870	16,072	3,560,186
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,185,135	25,386	7,849	10,734	2,229,104
56.00	05600	RADIOISOTOPE	-5,759	12	13	0	-5,734
57.00	05700	CT SCAN	662,972	4,230	3,681	3,008	673,891
58.00	05800	MRI	466,268	4,099	6,830	1,329	478,526
59.00	05900	CARDIAC CATHETERIZATION	201,182	0	5,054	31	206,267
60.00	06000	LABORATORY	2,236,970	10,119	757	5,391	2,253,237
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	193,977	505	0	0	194,482
64.00	06400	INTRAVENOUS THERAPY	1,365,443	12,484	698	5,947	1,384,572
65.00	06500	RESPIRATORY THERAPY	550,432	1,763	713	3,032	555,940
66.00	06600	PHYSICAL THERAPY	650,929	680	20	0	651,629
67.00	06700	OCCUPATIONAL THERAPY	76,765	214	6	0	76,985
68.00	06800	SPEECH PATHOLOGY	174,334	0	0	0	174,334
69.00	06900	ELECTROCARDIOLOGY	277,247	4,773	884	1,526	284,430
70.00	07000	ELECTROENCEPHALOGRAPHY	37,177	80	475	100	37,832
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,237,830	0	0	0	2,237,830
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,126,039	0	0	0	2,126,039
73.00	07300	DRUGS CHARGED TO PATIENTS	2,153,796	0	0	0	2,153,796
74.00	07400	RENAL DIALYSIS	0	556	0	0	556
76.00	03610	SLEEP LAB	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	381,434	15,168	621	2,087	399,310
91.00	09100	EMERGENCY	2,309,697	16,240	2,791	12,441	2,341,169
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,698,068	327,213	82,376	105,591	46,691,151
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	282,699	5,689	0	1,228	289,616
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	VACANT SPACE	0	0	0	0	0
194.01	07951	LEASED SPACE	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	46,980,767	332,902	82,376	106,819	46,980,767

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	11,440,023					5.00
7.00	00700	OPERATION OF PLANT	1,053,521	4,327,023				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,786	112,959	186,010			8.00
9.00	00900	HOUSEKEEPING	341,955	165,070	0	1,569,547		9.00
10.00	01000	DIETARY	74,389	0	0	0	305,531	10.00
11.00	01100	CAFETERIA	163,698	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	210,629	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,450	313,269	741	121,435	0	14.00
15.00	01500	PHARMACY	334,121	134,614	995	52,181	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,156	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,151,760	801,686	45,119	310,764	275,549	30.00
31.00	03100	INTENSIVE CARE UNIT	461,550	158,596	7,137	61,478	29,982	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,145,785	803,630	40,667	311,519	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	717,399	457,259	30,173	177,251	0	54.00
56.00	05600	RADIOISOTOPE	0	223	0	87	0	56.00
57.00	05700	CT SCAN	216,880	76,189	0	29,534	0	57.00
58.00	05800	MRI	154,005	73,829	3,398	28,619	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	66,384	0	0	0	0	59.00
60.00	06000	LABORATORY	725,166	182,259	36	70,651	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,591	9,089	0	3,523	0	63.00
64.00	06400	INTRAVENOUS THERAPY	445,601	224,866	14,990	87,167	0	64.00
65.00	06500	RESPIRATORY THERAPY	178,920	31,764	0	12,313	0	65.00
66.00	06600	PHYSICAL THERAPY	209,716	12,246	3,274	4,747	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,776	3,859	0	1,496	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,106	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	91,539	85,979	0	33,329	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,176	1,435	0	556	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	720,208	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	684,230	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	693,163	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	179	10,014	0	3,882	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	128,511	273,213	96	105,908	0	90.00
91.00	09100	EMERGENCY	753,465	292,508	39,384	113,387	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,346,815	4,224,556	186,010	1,529,827	305,531	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93,208	102,467	0	39,720	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,440,023	4,327,023	186,010	1,569,547	305,531	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	672,340					11.00
13.00	01300	NURSING ADMINISTRATION	30	865,126				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,413	0	1,534,685			14.00
15.00	01500	PHARMACY	23,983	0	2,171	1,586,246		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	776,901	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108,863	780,229	86,624	0	84,049	30.00
31.00	03100	INTENSIVE CARE UNIT	48,712	84,897	90	0	39,872	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	103,710	0	964,619	0	358,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,843	0	72,195	0	0	54.00
56.00	05600	RADIOISOTOPE	30	0	0	0	0	56.00
57.00	05700	CT SCAN	18,293	0	43,064	0	0	57.00
58.00	05800	MRI	7,657	0	4,510	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	149	0	1,033	0	0	59.00
60.00	06000	LABORATORY	39,684	0	3,517	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	38,493	0	1,689	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,902	0	17,784	0	36,021	65.00
66.00	06600	PHYSICAL THERAPY	0	0	21	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,772	0	1,533	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	804	0	21,494	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	101,443	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	153,598	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,586,246	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	76,360	0	548	0	0	90.00
91.00	09100	EMERGENCY	71,533	0	58,752	0	258,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	659,231	865,126	1,534,685	1,586,246	776,901	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,109	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	672,340	865,126	1,534,685	1,586,246	776,901	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0120

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,223,418	0	7,223,418	30.00
31.00	03100	INTENSIVE CARE UNIT	2,326,443	0	2,326,443	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,288,964	0	7,288,964	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,749,224	0	3,749,224	54.00
56.00	05600	RADIOISOTOPE	-5,394	0	-5,394	56.00
57.00	05700	CT SCAN	1,057,851	0	1,057,851	57.00
58.00	05800	MRI	750,544	0	750,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	273,833	0	273,833	59.00
60.00	06000	LABORATORY	3,274,550	0	3,274,550	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	269,685	0	269,685	63.00
64.00	06400	INTRAVENOUS THERAPY	2,197,378	0	2,197,378	64.00
65.00	06500	RESPIRATORY THERAPY	852,644	0	852,644	65.00
66.00	06600	PHYSICAL THERAPY	881,633	0	881,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,116	0	107,116	67.00
68.00	06800	SPEECH PATHOLOGY	230,440	0	230,440	68.00
69.00	06900	ELECTROCARDIOLOGY	506,582	0	506,582	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,297	0	74,297	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,059,481	0	3,059,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,963,867	0	2,963,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,433,205	0	4,433,205	73.00
74.00	07400	RENAL DIALYSIS	14,631	0	14,631	74.00
76.00	03610	SLEEP LAB	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	983,946	0	983,946	90.00
91.00	09100	EMERGENCY	3,928,309	0	3,928,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,442,647	0	46,442,647	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	538,120	0	538,120	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,980,767	0	46,980,767	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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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	6,668	0	6,668	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,756	9,835	1,680	75,271	5.00
7.00	00700	OPERATION OF PLANT	0	76,171	28,103	104,274	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,066,799	6,271	383	1,073,453	8.00
9.00	00900	HOUSEKEEPING	14,546	9,164	161	23,871	9.00
10.00	01000	DIETARY	6,093	0	0	6,093	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,392	1,015	18,407	14.00
15.00	01500	PHARMACY	80,030	7,474	3,497	91,001	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132,749	0	0	132,749	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	77,896	44,508	2,052	124,456	30.00
31.00	03100	INTENSIVE CARE UNIT	8,466	8,805	223	17,494	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	530,895	44,616	14,870	590,381	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,930	25,386	7,849	330,165	54.00
56.00	05600	RADIOISOTOPE	498	12	13	523	56.00
57.00	05700	CT SCAN	139,744	4,230	3,681	147,655	57.00
58.00	05800	MRI	236,758	4,099	6,830	247,687	58.00
59.00	05900	CARDIAC CATHETERIZATION	191,868	0	5,054	196,922	59.00
60.00	06000	LABORATORY	28,720	10,119	757	39,596	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	505	0	505	63.00
64.00	06400	INTRAVENOUS THERAPY	26,502	12,484	698	39,684	64.00
65.00	06500	RESPIRATORY THERAPY	17,130	1,763	713	19,606	65.00
66.00	06600	PHYSICAL THERAPY	757	680	20	1,457	66.00
67.00	06700	OCCUPATIONAL THERAPY	239	214	6	459	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,539	4,773	884	39,196	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	558	80	475	1,113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,564	0	0	44,564	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	556	0	556	74.00
76.00	03610	SLEEP LAB	17,476	0	0	17,476	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	23,573	15,168	621	39,362	90.00
91.00	09100	EMERGENCY	105,953	16,240	2,791	124,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,146,039	327,213	82,376	3,555,628	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,689	0	5,689	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,146,039	332,902	82,376	3,561,317	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	75,359					5.00
7.00	00700	OPERATION OF PLANT	6,940	111,439				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117	2,909	1,076,495			8.00
9.00	00900	HOUSEKEEPING	2,253	4,251	0	30,672		9.00
10.00	01000	DIETARY	490	0	0	0	6,648	10.00
11.00	01100	CAFETERIA	1,078	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,387	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,722	8,068	4,290	2,373	0	14.00
15.00	01500	PHARMACY	2,201	3,467	5,756	1,020	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,246	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,589	20,647	261,114	6,073	5,996	30.00
31.00	03100	INTENSIVE CARE UNIT	3,040	4,085	41,305	1,201	652	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,548	20,699	235,352	6,087	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,726	11,776	174,619	3,464	0	54.00
56.00	05600	RADIOISOTOPE	0	6	0	2	0	56.00
57.00	05700	CT SCAN	1,429	1,962	0	577	0	57.00
58.00	05800	MRI	1,014	1,901	19,666	559	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	437	0	0	0	0	59.00
60.00	06000	LABORATORY	4,777	4,694	209	1,381	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	412	234	0	69	0	63.00
64.00	06400	INTRAVENOUS THERAPY	2,935	5,791	86,750	1,703	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,179	818	0	241	0	65.00
66.00	06600	PHYSICAL THERAPY	1,381	315	18,947	93	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	163	99	0	29	0	67.00
68.00	06800	SPEECH PATHOLOGY	370	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	603	2,214	0	651	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80	37	0	11	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,744	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,507	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,566	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1	258	0	76	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	847	7,036	557	2,070	0	90.00
91.00	09100	EMERGENCY	4,963	7,533	227,930	2,216	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,745	108,800	1,076,495	29,896	6,648	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	614	2,639	0	776	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	75,359	111,439	1,076,495	30,672	6,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,283					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,387				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48	0	35,066			14.00
15.00	01500	PHARMACY	46	0	50	103,871		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	133,995	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	206	1,251	1,979	0	14,496	30.00
31.00	03100	INTENSIVE CARE UNIT	93	136	2	0	6,877	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	198	0	22,041	0	61,892	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126	0	1,650	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	35	0	984	0	0	57.00
58.00	05800	MRI	15	0	103	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	24	0	0	59.00
60.00	06000	LABORATORY	76	0	80	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	73	0	39	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	38	0	406	0	6,213	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19	0	35	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2	0	491	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,318	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,509	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,871	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	146	0	13	0	0	90.00
91.00	09100	EMERGENCY	137	0	1,342	0	44,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,258	1,387	35,066	103,871	133,995	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,283	1,387	35,066	103,871	133,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	444,744	0	444,744	30.00
31.00	03100	INTENSIVE CARE UNIT	75,304	0	75,304	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	945,203	0	945,203	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	527,196	0	527,196	54.00
56.00	05600	RADIOISOTOPE	531	0	531	56.00
57.00	05700	CT SCAN	152,830	0	152,830	57.00
58.00	05800	MRI	271,028	0	271,028	58.00
59.00	05900	CARDIAC CATHETERIZATION	197,385	0	197,385	59.00
60.00	06000	LABORATORY	51,149	0	51,149	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,220	0	1,220	63.00
64.00	06400	INTRAVENOUS THERAPY	137,346	0	137,346	64.00
65.00	06500	RESPIRATORY THERAPY	28,690	0	28,690	65.00
66.00	06600	PHYSICAL THERAPY	22,193	0	22,193	66.00
67.00	06700	OCCUPATIONAL THERAPY	750	0	750	67.00
68.00	06800	SPEECH PATHOLOGY	370	0	370	68.00
69.00	06900	ELECTROCARDIOLOGY	42,813	0	42,813	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,740	0	1,740	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,626	0	51,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,016	0	8,016	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,437	0	108,437	73.00
74.00	07400	RENAL DIALYSIS	891	0	891	74.00
76.00	03610	SLEEP LAB	17,476	0	17,476	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	50,161	0	50,161	90.00
91.00	09100	EMERGENCY	414,398	0	414,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,551,497	0	3,551,497	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,820	0	9,820	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,561,317	0	3,561,317	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	188,021					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,127,038				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,766	0	14,303,369			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,555	63,756	187,819	-11,440,023	35,546,478	5.00
7.00	00700	OPERATION OF PLANT	43,020	1,066,799	482,477	0	3,273,502	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,542	14,546	33,868	0	55,265	8.00
9.00	00900	HOUSEKEEPING	5,176	6,093	636,872	0	1,062,522	9.00
10.00	01000	DIETARY	0	0	139,325	0	231,142	10.00
11.00	01100	CAFETERIA	0	0	439,547	0	508,642	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	430	0	654,467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,823	38,529	339,504	0	812,377	14.00
15.00	01500	PHARMACY	4,221	132,749	708,386	0	1,038,181	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	587,745	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,138	77,896	2,010,092	0	3,578,775	30.00
31.00	03100	INTENSIVE CARE UNIT	4,973	8,466	899,289	0	1,434,129	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,199	564,479	2,151,863	0	3,560,186	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,338	297,965	1,437,391	0	2,229,104	54.00
56.00	05600	RADIOISOTOPE	7	498	0	5,734	0	56.00
57.00	05700	CT SCAN	2,389	139,744	402,847	0	673,891	57.00
58.00	05800	MRI	2,315	259,258	177,967	0	478,526	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	191,868	4,214	0	206,267	59.00
60.00	06000	LABORATORY	5,715	28,720	721,847	0	2,253,237	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	285	0	0	0	194,482	63.00
64.00	06400	INTRAVENOUS THERAPY	7,051	26,502	796,310	0	1,384,572	64.00
65.00	06500	RESPIRATORY THERAPY	996	27,075	405,936	0	555,940	65.00
66.00	06600	PHYSICAL THERAPY	384	757	0	0	651,629	66.00
67.00	06700	OCCUPATIONAL THERAPY	121	239	0	0	76,985	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	174,334	68.00
69.00	06900	ELECTROCARDIOLOGY	2,696	33,539	204,302	0	284,430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45	18,034	13,428	0	37,832	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,237,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,126,039	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,153,796	73.00
74.00	07400	RENAL DIALYSIS	314	0	0	0	556	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,567	23,573	279,400	0	399,310	90.00
91.00	09100	EMERGENCY	9,172	105,953	1,665,885	0	2,341,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	184,808	3,127,038	14,138,999	-11,434,289	35,256,862	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,213	0	164,370	0	289,616	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	332,902	82,376	106,819		11,440,023	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.770558	0.026343	0.007468		0.321833	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,668		75,359	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000466		0.002120	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0120

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	135,680				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,542	344,306			8.00
9.00	00900	HOUSEKEEPING	5,176	0	126,962		9.00
10.00	01000	DIETARY	0	0	0	24,732	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,823	1,372	9,823	0	14.00
15.00	01500	PHARMACY	4,221	1,841	4,221	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,138	83,515	25,138	22,305	30.00
31.00	03100	INTENSIVE CARE UNIT	4,973	13,211	4,973	2,427	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,199	75,275	25,199	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,338	55,850	14,338	0	54.00
56.00	05600	RADIOISOTOPE	7	0	7	0	56.00
57.00	05700	CT SCAN	2,389	0	2,389	0	57.00
58.00	05800	MRI	2,315	6,290	2,315	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	5,715	67	5,715	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	285	0	285	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,051	27,746	7,051	0	64.00
65.00	06500	RESPIRATORY THERAPY	996	0	996	0	65.00
66.00	06600	PHYSICAL THERAPY	384	6,060	384	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	121	0	121	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,696	0	2,696	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45	0	45	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	314	0	314	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,567	178	8,567	0	90.00
91.00	09100	EMERGENCY	9,172	72,901	9,172	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	132,467	344,306	123,749	24,732	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,213	0	3,213	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,327,023	186,010	1,569,547	305,531	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.891384	0.540246	12.362337	12.353671	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	111,439	1,076,495	30,672	6,648	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.821337	3.126565	0.241584	0.268802	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: 14-0120

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	8,244				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,328,974			14.00
15.00	01500	PHARMACY	0	6,125	305,800		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	29,052	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,435	244,346	0	3,143	30.00
31.00	03100	INTENSIVE CARE UNIT	809	255	0	1,491	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,720,951	0	13,419	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,645	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	121,474	0	0	57.00
58.00	05800	MRI	0	12,721	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,915	0	0	59.00
60.00	06000	LABORATORY	0	9,921	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	4,763	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	50,164	0	1,347	65.00
66.00	06600	PHYSICAL THERAPY	0	60	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,325	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	60,630	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	286,146	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	433,262	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	305,800	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,545	0	0	90.00
91.00	09100	EMERGENCY	0	165,726	0	9,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,244	4,328,974	305,800	29,052	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	865,126	1,534,685	1,586,246	776,901	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	104.940078	0.354515	5.187201	26.741739	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,387	35,066	103,871	133,995	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.168244	0.008100	0.339670	4.612247	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,223,418		7,223,418	0	7,223,418	30.00
31.00	03100	INTENSIVE CARE UNIT	2,326,443		2,326,443	0	2,326,443	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,288,964		7,288,964	0	7,288,964	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,749,224		3,749,224	0	3,749,224	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	1,057,851		1,057,851	0	1,057,851	57.00
58.00	05800	MRI	750,544		750,544	0	750,544	58.00
59.00	05900	CARDIAC CATHETERIZATION	273,833		273,833	0	273,833	59.00
60.00	06000	LABORATORY	3,274,550		3,274,550	0	3,274,550	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	269,685		269,685	0	269,685	63.00
64.00	06400	INTRAVENOUS THERAPY	2,197,378		2,197,378	0	2,197,378	64.00
65.00	06500	RESPIRATORY THERAPY	852,644	0	852,644	0	852,644	65.00
66.00	06600	PHYSICAL THERAPY	881,633	0	881,633	0	881,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,116	0	107,116	0	107,116	67.00
68.00	06800	SPEECH PATHOLOGY	230,440	0	230,440	0	230,440	68.00
69.00	06900	ELECTROCARDIOLOGY	506,582		506,582	0	506,582	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,297		74,297	0	74,297	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,059,481		3,059,481	0	3,059,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,963,867		2,963,867	0	2,963,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,433,205		4,433,205	0	4,433,205	73.00
74.00	07400	RENAL DIALYSIS	14,631		14,631	0	14,631	74.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	983,946		983,946	0	983,946	90.00
91.00	09100	EMERGENCY	3,928,309		3,928,309	0	3,928,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,752,699		1,752,699		1,752,699	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	48,200,740	0	48,200,740	0	48,200,740	200.00
201.00		Less Observation Beds	1,752,699		1,752,699		1,752,699	201.00
202.00		Total (see instructions)	46,448,041	0	46,448,041	0	46,448,041	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,741,608		16,741,608			30.00
31.00	03100	INTENSIVE CARE UNIT	7,941,208		7,941,208			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,680,945	63,799,229	71,480,174	0.101972	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555,353	22,190,225	24,745,578	0.151511	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	7,133,031	40,232,138	47,365,169	0.022334	0.000000	57.00
58.00	05800	MRI	1,220,904	12,988,783	14,209,687	0.052819	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	11,920,536	26,695,419	38,615,955	0.084798	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	828,850	614,302	1,443,152	0.186872	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,022,612	11,147,235	13,169,847	0.166849	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,976,548	2,200,256	7,176,804	0.118806	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	670,245	1,300,680	1,970,925	0.447319	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,074	137,756	441,830	0.242437	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	282,785	473,094	755,879	0.304864	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,233,669	6,069,135	8,302,804	0.061013	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,949	58,741	78,690	0.944173	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,634,470	5,478,416	10,112,886	0.302533	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,865,285	8,321,459	10,186,744	0.290953	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,803,082	9,387,528	17,190,610	0.257885	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	29,699	29,699	0.492643	0.000000	74.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,264,198	3,976,265	5,240,463	0.187759	0.000000	90.00
91.00	09100	EMERGENCY	6,359,600	45,059,383	51,418,983	0.076398	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	365,600	3,743,179	4,108,779	0.426574	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	88,824,552	263,902,922	352,727,474			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	88,824,552	263,902,922	352,727,474			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/22/2022 5:15 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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.101972		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151511		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.022334		57.00
58.00	05800	MRI	0.052819		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.084798		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.186872		63.00
64.00	06400	INTRAVENOUS THERAPY	0.166849		64.00
65.00	06500	RESPIRATORY THERAPY	0.118806		65.00
66.00	06600	PHYSICAL THERAPY	0.447319		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242437		67.00
68.00	06800	SPEECH PATHOLOGY	0.304864		68.00
69.00	06900	ELECTROCARDIOLOGY	0.061013		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.944173		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302533		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.290953		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257885		73.00
74.00	07400	RENAL DIALYSIS	0.492643		74.00
76.00	03610	SLEEP LAB	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.187759		90.00
91.00	09100	EMERGENCY	0.076398		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.426574		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	444,744	0	444,744	9,817	45.30	30.00	
31.00	INTENSIVE CARE UNIT	75,304		75,304	809	93.08	31.00	
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30 through 199)	520,048		520,048	10,626		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,044	137,893					30.00
31.00	INTENSIVE CARE UNIT	345	32,113					31.00
33.00	BURN INTENSIVE CARE UNIT	0	0					33.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	3,389	170,006					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/22/2022 5:15 pm

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	945,203	71,480,174	0.013223	2,720,039	35,967	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	527,196	24,745,578	0.021305	1,071,419	22,827	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	152,830	47,365,169	0.003227	2,706,076	8,733	57.00
58.00	05800 MRI	271,028	14,209,687	0.019073	495,755	9,456	58.00
59.00	05900 CARDIAC CATHETERIZATION	197,385	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	51,149	38,615,955	0.001325	4,900,775	6,494	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,220	1,443,152	0.000845	423,423	358	63.00
64.00	06400 INTRAVENOUS THERAPY	137,346	13,169,847	0.010429	770,431	8,035	64.00
65.00	06500 RESPIRATORY THERAPY	28,690	7,176,804	0.003998	1,394,267	5,574	65.00
66.00	06600 PHYSICAL THERAPY	22,193	1,970,925	0.011260	332,716	3,746	66.00
67.00	06700 OCCUPATIONAL THERAPY	750	441,830	0.001697	135,139	229	67.00
68.00	06800 SPEECH PATHOLOGY	370	755,879	0.000489	144,598	71	68.00
69.00	06900 ELECTROCARDIOLOGY	42,813	8,302,804	0.005156	1,770,363	9,128	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,740	78,690	0.022112	4,938	109	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	51,626	10,112,886	0.005105	1,732,571	8,845	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8,016	10,186,744	0.000787	807,736	636	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	108,437	17,190,610	0.006308	2,902,293	18,308	73.00
74.00	07400 RENAL DIALYSIS	891	29,699	0.030001	0	0	74.00
76.00	03610 SLEEP LAB	17,476	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	50,161	5,240,463	0.009572	475,970	4,556	90.00
91.00	09100 EMERGENCY	414,398	51,418,983	0.008059	2,347,758	18,921	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	107,914	4,108,779	0.026264	187,200	4,917	92.00
200.00	Total (lines 50 through 199)	3,138,832	328,044,658		25,323,467	166,910	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/22/2022 5:15 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	9,817	0.00	3,044	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	809	0.00	345	31.00		
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00		
43.00	04300	NURSERY		0	0	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	10,626		3,389	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	
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 5:15 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/22/2022 5:15 pm

				Title XVIII		Hospital	PPS
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	71,480,174	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,745,578	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000
57.00	05700	CT SCAN	0	0	0	47,365,169	0.000000
58.00	05800	MRI	0	0	0	14,209,687	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	38,615,955	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,443,152	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	13,169,847	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,176,804	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,970,925	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	441,830	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	755,879	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,302,804	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	78,690	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,112,886	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,186,744	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,190,610	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	29,699	0.000000
76.00	03610	SLEEP LAB	0	0	0	0	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,240,463	0.000000
91.00	09100	EMERGENCY	0	0	0	51,418,983	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,108,779	0.000000
200.00		Total (lines 50 through 199)	0	0	0	328,044,658	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0120

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2022 5:15 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	2,720,039	0	13,473,403	0	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,071,419	0	4,557,024	0	54.00	
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700 CT SCAN	0.000000	2,706,076	0	10,108,783	0	57.00	
58.00	05800 MRI	0.000000	495,755	0	3,423,613	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	4,900,775	0	3,793,670	0	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	423,423	0	268,663	0	63.00	
64.00	06400 INTRAVENOUS THERAPY	0.000000	770,431	0	2,523,727	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	1,394,267	0	198,797	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	332,716	0	53,415	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	135,139	0	9,242	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	144,598	0	13,519	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,770,363	0	2,958,034	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	4,938	0	16,388	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,732,571	0	1,373,049	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	807,736	0	2,853,475	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,902,293	0	2,208,995	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	0	0	29,699	0	74.00	
76.00	03610 SLEEP LAB	0.000000	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	475,970	0	1,241,019	0	90.00	
91.00	09100 EMERGENCY	0.000000	2,347,758	0	7,257,570	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	187,200	0	696,744	0	92.00	
200.00	Total (lines 50 through 199)		25,323,467	0	57,058,829	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/22/2022 5:15 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.101972	13,473,403	0	0	1,373,910	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.151511	4,557,024	0	0	690,439	54.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.022334	10,108,783	0	0	225,770	57.00
58.00	05800	MRI		0.052819	3,423,613	0	0	180,832	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.084798	3,793,670	3,762	0	321,696	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.186872	268,663	0	0	50,206	63.00
64.00	06400	INTRAVENOUS THERAPY		0.166849	2,523,727	0	0	421,081	64.00
65.00	06500	RESPIRATORY THERAPY		0.118806	198,797	0	0	23,618	65.00
66.00	06600	PHYSICAL THERAPY		0.447319	53,415	0	0	23,894	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.242437	9,242	0	0	2,241	67.00
68.00	06800	SPEECH PATHOLOGY		0.304864	13,519	0	0	4,121	68.00
69.00	06900	ELECTROCARDIOLOGY		0.061013	2,958,034	0	0	180,479	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.944173	16,388	0	0	15,473	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.302533	1,373,049	0	0	415,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.290953	2,853,475	0	0	830,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.257885	2,208,995	0	1,604	569,667	73.00
74.00	07400	RENAL DIALYSIS		0.492643	29,699	0	0	14,631	74.00
76.00	03610	SLEEP LAB		0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.187759	1,241,019	0	0	233,012	90.00
91.00	09100	EMERGENCY		0.076398	7,257,570	0	0	554,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.426574	696,744	0	0	297,213	92.00
200.00		Subtotal (see instructions)			57,058,829	3,762	1,604	6,428,367	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			57,058,829	3,762	1,604	6,428,367	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0120		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/22/2022 5:15 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	319	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	414					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03610	SLEEP LAB	0	0					76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	319	414					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	319	414					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 5:15 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,817	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,817	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,435	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,044	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)		7,223,418	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)		7,223,418	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)		7,223,418	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)		735.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,239,806	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)		2,239,806	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

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

Worksheet D-1

Date/Time Prepared:
5/22/2022 5:15 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,326,443	809	2,875.70	345	992,117	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					3,509,789	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,741,712	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)					170,006	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					166,910	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					336,916	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,404,796	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)					2,382	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					735.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,752,699	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0120

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

Worksheet D-1

Date/Time Prepared:
5/22/2022 5:15 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	444,744	7,223,418	0.061570	1,752,699	107,914	90.00
91.00 Nursing Program cost	0	7,223,418	0.000000	1,752,699	0	91.00
92.00 Allied health cost	0	7,223,418	0.000000	1,752,699	0	92.00
93.00 All other Medical Education	0	7,223,418	0.000000	1,752,699	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/22/2022 5:15 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		7,003,407		30.00
31.00	03100	INTENSIVE CARE UNIT		3,106,868		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.101972	2,720,039	277,368	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151511	1,071,419	162,332	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.022334	2,706,076	60,438	57.00
58.00	05800	MRI	0.052819	495,755	26,185	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.084798	4,900,775	415,576	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.186872	423,423	79,126	63.00
64.00	06400	INTRAVENOUS THERAPY	0.166849	770,431	128,546	64.00
65.00	06500	RESPIRATORY THERAPY	0.118806	1,394,267	165,647	65.00
66.00	06600	PHYSICAL THERAPY	0.447319	332,716	148,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242437	135,139	32,763	67.00
68.00	06800	SPEECH PATHOLOGY	0.304864	144,598	44,083	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061013	1,770,363	108,015	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.944173	4,938	4,662	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.302533	1,732,571	524,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.290953	807,736	235,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257885	2,902,293	748,458	73.00
74.00	07400	RENAL DIALYSIS	0.492643	0	0	74.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.187759	475,970	89,368	90.00
91.00	09100	EMERGENCY	0.076398	2,347,758	179,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.426574	187,200	79,855	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,323,467	3,509,789	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		25,323,467		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A
Date/Time Prepared:
5/22/2022 5:15 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			4,554,909	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,331,489	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)			37,296	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			4,139	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			38.47	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)			3.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)			12.30	31.00
32.00	Sum of lines 30 and 31			16.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)			3.09	33.00
34.00	Disproportionate share adjustment (see instructions)			45,473	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/22/2022 5:15 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		554,248	255,660	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		414,547	64,440	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		478,987		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,452,293		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)			6,452,293	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			444,306	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			50,892	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)			6,947,491	59.00
60.00	Primary payer payments			11,703	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			6,935,788	61.00
62.00	Deductibles billed to program beneficiaries			717,572	62.00
63.00	Coinsurance billed to program beneficiaries			7,420	63.00
64.00	Allowable bad debts (see instructions)			21,632	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			14,061	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			739	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6,224,857	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			36,754	70.93
70.94	HRR adjustment amount (see instructions)			-126,453	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/22/2022 5:15 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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)		68,578	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,066,580	71.00	
71.01	Sequestration adjustment (see instructions)		0	71.01	
71.02	Demonstration payment adjustment amount after sequestration		89,197	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		5,911,899	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		65,484	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/22/2022 5:15 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,554,909	0	4,554,909		4,554,909
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,331,489	0		1,331,489	1,331,489
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	37,296	0	37,296		37,296
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,139	0		4,139	4,139
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0309	0.0309	0.0309	0.0309	
11.00	Disproportionate share adjustment (see instructions)	34.00	45,473	0	35,187	10,286	45,473
11.01	Uncompensated care payments	36.00	478,987	0	414,547	64,440	478,987
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	6,452,293	0	5,041,939	1,410,354	6,452,293
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	6,452,293	0	5,041,939	1,410,354	6,452,293
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	444,306	0	347,362	96,944	444,306

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/22/2022 5:15 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	50,892	0	31,399	19,493	50,892	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,420,700	1,526,791	6,947,491	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	442,381	0	345,476	96,905	442,381	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,925	0	1,886	39	1,925	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	444,306	0	347,362	96,944	444,306	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/22/2022 5:15 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,554,909	4,554,909		4,554,909	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,331,489		1,331,489	1,331,489	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	37,296	37,296		37,296	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,139		4,139	4,139	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0309	0.0309	0.0309		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	45,473	35,187	10,286	45,473	11.00
11.01	Uncompensated care payments	36.00	478,987	414,547	64,440	478,987	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,452,293	5,041,939	1,410,354	6,452,293	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,452,293	5,041,939	1,410,354	6,452,293	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	444,306	347,362	96,944	444,306	16.00
17.00	Special add-on payments for new technologies	54.00	50,892	31,399	19,493	50,892	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,420,700	1,526,791	6,947,491	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/22/2022 5:15 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	442,381	345,476	96,905	442,381	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	1,925	1,886	39	1,925	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	444,306	347,362	96,944	444,306	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	36,754	36,754	0	36,754	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	-126,453	-104,568	-21,885	-126,453	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		53,529	15,049	68,578	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/22/2022 5:15 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		733	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,428,367	2.00
3.00	OPPS payments		5,952,156	3.00
4.00	Outlier payment (see instructions)		6,400	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		733	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,366	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		5,366	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		5,366	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,633	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)		733	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)		5,958,556	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,104,011	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)		4,855,278	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)		4,855,278	30.00
31.00	Primary payer payments		929	31.00
32.00	Subtotal (line 30 minus line 31)		4,854,349	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)		21,655	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		14,076	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		656	36.00
37.00	Subtotal (see instructions)		4,868,425	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-21	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,868,446	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		85,939	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		4,858,346	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-75,839	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		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: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/22/2022 5:15 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,911,899		4,858,346	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,911,899		4,858,346	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		65,484		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		75,839	6.02
7.00	Total Medicare program liability (see instructions)		5,977,383		4,782,507	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: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/22/2022 5:15 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

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

Provider CCN: 14-0120

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

Worksheet G

Date/Time Prepared:
5/22/2022 5:15 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	8,305,279	0	0	0	1.00
2.00 Temporary investments	3,822,827	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	6,809,938	0	0	0	4.00
5.00 Other receivable	2,820,256	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	1,440,646	0	0	0	7.00
8.00 Prepaid expenses	157,067	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	7,972,247	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	31,328,260	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,430,968	0	0	0	12.00
13.00 Land improvements	13,148,005	0	0	0	13.00
14.00 Accumulated depreciation	-2,092,371	0	0	0	14.00
15.00 Buildings	1,035,873	0	0	0	15.00
16.00 Accumulated depreciation	0	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	6,429,427	0	0	0	19.00
20.00 Accumulated depreciation	-2,508,862	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	9,628,857	0	0	0	23.00
24.00 Accumulated depreciation	-2,861,947	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)	25,209,950	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	13,511,898	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	13,511,898	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	70,050,108	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,978,340	0	0	0	37.00
38.00 Salaries, wages, and fees payable	7,396,883	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	5,136,641	0	0	0	43.00
44.00 Other current liabilities	6,759,603	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	21,271,467	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	13,380,790	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	13,380,790	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	34,652,257	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	35,397,851	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	35,397,851	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	70,050,108	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0120

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

Worksheet G-1

Date/Time Prepared:
5/22/2022 5:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,215,532		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		12,289,428				2.00
3.00	Total (sum of line 1 and line 2)		35,504,960		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		35,504,960		0		11.00
12.00	CHANGES IN UNRESTRICTED FUND BALANCE	107,110		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)		107,110		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35,397,850		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGES IN UNRESTRICTED FUND BALANCE		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0120

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/22/2022 5:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	21,032,277		21,032,277	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	0		0	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)	21,032,277		21,032,277	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,759,347		4,759,347	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	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)	4,759,347		4,759,347	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,791,624		25,791,624	17.00
18.00	Ancillary services	63,041,685	0	63,041,685	18.00
19.00	Outpatient services	0	268,687,590	268,687,590	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	88,833,309	268,687,590	357,520,899	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,985,878		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)		41,985,878		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0120

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

Worksheet G-3

Date/Time Prepared:
5/22/2022 5:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	357,520,899	1.00
2.00	Less contractual allowances and discounts on patients' accounts	297,851,731	2.00
3.00	Net patient revenues (line 1 minus line 2)	59,669,168	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,985,878	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,683,290	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	104,330	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	218,672	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PEKIN AND HOME OFFICE REVENUE	500,011	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	823,013	25.00
26.00	Total (line 5 plus line 25)	18,506,303	26.00
27.00	PEORIA HOME OFFICE EXPENSES	6,216,875	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	6,216,875	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,289,428	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0120	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/22/2022 5:15 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		442,381	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,925	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)		22.62	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		444,306	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