

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: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/22/2022 10:34 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/22/2022	Time: 10:34 am
	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 GATEWAY REGIONAL (14-0125) 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	Anil Jain	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Anil Jain		2
3	Signatory Title	CFO		3
4	Date	(Dated when report is electronically)		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	107,220	-54,802	0	0	1.00
2.00 Subprovider - IPF	0	-85,237	5		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
200.00 Total	0	21,983	-54,797	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: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 10:34 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2100 MADISON AVE			PO Box:				1.00	
2.00	City: GRANITE CITY			State: IL		Zip Code: 62040		County: MADISON 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			GATEWAY REGIONAL	140125	41180	1	07/01/1969	N
4.00	Subprovider - IPF			PSYCH DPU	14S125	41180	4	01/01/1984	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								P
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00

Worksheet S-2
Part I
Date/Time Prepared:
5/22/2022 10:34 am

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 10:34 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/22/2022 10:34 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	525,578	987,275	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

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1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: QUORUM HEALTH CORPORATION		Contractor's Name: WPS		Contractor's Number: 52280				141.00
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100						142.00
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027				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.				Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				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		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
									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
		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
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)								
168.01	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)								
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99
						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)								
						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: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/22/2022 10:34 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			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.					Y	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)			Y	04/13/2022	Y	04/13/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/22/2022 10:34 am

		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.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHRIS	WHITE		41.00
42.00	Enter the employer/company name of the cost report preparer	QHC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 221-3792	CWHITE@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/22/2022 10:34 am
		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.	V.P. REVENUE MANAGEMENT		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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/22/2022 10:34 am

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	276	100,740	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)		276	100,740	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		288	105,120	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	17	6,205		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	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						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)		305			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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/22/2022 10:34 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,157	204	17,585			1.00
2.00	HMO and other (see instructions)	409	9,191				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)	2,157	204	17,585			7.00
8.00	INTENSIVE CARE UNIT	420	56	1,491			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	2,577	260	19,076	0.00	418.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	212	1,021	3,383	0.00	14.80	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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						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	432.89	27.00
28.00	Observation Bed Days		0	2,107			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/22/2022 10:34 am

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	1,034	64	4,773	1.00
2.00 HMO and other (see instructions)			80	2,251		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	1,034	64	4,773	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	27	123	545	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	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						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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/22/2022 10:34 am

	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	29,650,328	0	29,650,328	900,420.00	32.93
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)		1,132,484	107,512	1,239,996	32,843.00	37.76
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,500,423	0	2,500,423	30,675.00	81.51
12.00	Contract labor: Top level management and other management and administrative services		3,476	0	3,476	34.00	102.24
13.00	Contract labor: Physician-Part A - Administrative		132,235	0	132,235	986.00	134.11
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		1,955,848	0	1,955,848	25,198.00	77.62
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)		6,394,602	0	6,394,602		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		259,152	0	259,152		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/22/2022 10:34 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	287,987	0	287,987	9,026.00	31.91	26.00
27.00	Administrative & General	5.00	3,647,190	505,216	4,152,406	0.00	0.00	27.00
28.00	Administrative & General under contract (see inst.)		1,157,815	0	1,157,815	48,131.00	24.06	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	838,647	0	838,647	29,129.00	28.79	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,715,414	0	1,715,414	76,613.00	22.39	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,098,431	0	1,098,431	31,002.00	35.43	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,708,037	0	1,708,037	43,389.00	39.37	38.00
39.00	Central Services and Supply	14.00	154,233	0	154,233	7,785.00	19.81	39.00
40.00	Pharmacy	15.00	1,298,401	0	1,298,401	33,816.00	38.40	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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/22/2022 10:34 am

	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)	33,621,988	0	33,621,988	1,056,166.00	31.83	1.00
2.00	Excluded area salaries (see instructions)	1,132,484	107,512	1,239,996	32,843.00	37.76	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,489,504	-107,512	32,381,992	1,023,323.00	31.64	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,591,982	0	4,591,982	56,893.00	80.71	4.00
5.00	Subtotal wage-related costs (see inst.)	6,394,602	0	6,394,602	0.00	19.75	5.00
6.00	Total (sum of lines 3 thru 5)	43,476,088	-107,512	43,368,576	1,080,216.00	40.15	6.00
7.00	Total overhead cost (see instructions)	11,906,155	505,216	12,411,371	278,891.00	44.50	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2022 10:34 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		254,944	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		2,981,431	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		16,043	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		19,440	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		-22	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		13,388	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		559,152	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		1,823,711	17.00
18.00	Medicare Taxes - Employers Portion Only		426,513	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		127,534	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,222,134	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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/22/2022 10:34 am

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	2,500,423	6,222,134	1.00
2.00	Hospital	2,500,423	6,222,134	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	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			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: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/22/2022 10:34 am	
				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)		0.108324		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		31,136,992		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		13,415,933		5.00
6.00	Medicaid charges		272,920,466		6.00
7.00	Medicaid cost (line 1 times line 6)		29,563,837		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		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)		0		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)	8,426,122	0	8,426,122	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	912,751	0	912,751	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)	912,751	0	912,751	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)		22,162,698		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		515,235		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		792,669		27.01
28.00	Non-Medicare bad debt expense (see instructions)		21,370,029		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,592,321		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,505,072		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,505,072		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0125

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

Worksheet A

Date/Time Prepared:
5/22/2022 10:34 am

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		1,069,590	1,069,590	1,362,878	2,432,468 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,037,723	3,037,723	15,676	3,053,399 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	287,987	110,746	398,733	4,249,173	4,647,906 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,647,190	33,309,202	36,956,392	-4,861,621	32,094,771 5.00
7.00	00700	OPERATION OF PLANT	838,647	3,925,568	4,764,215	-2,968	4,761,247 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,768	254,768	0	254,768 8.00
9.00	00900	HOUSEKEEPING	0	1,980,418	1,980,418	0	1,980,418 9.00
10.00	01000	DIETARY	0	1,936,564	1,936,564	-368,090	1,568,474 10.00
11.00	01100	CAFETERIA	0	0	0	368,090	368,090 11.00
13.00	01300	NURSING ADMINISTRATION	1,708,037	647,252	2,355,289	-335,599	2,019,690 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	154,233	54,209	208,442	121,514	329,956 14.00
15.00	01500	PHARMACY	1,298,401	1,550,362	2,848,763	-1,096,781	1,751,982 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	270,232	270,232	0	270,232 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,347,279	4,720,064	11,067,343	239,629	11,306,972 30.00
31.00	03100	INTENSIVE CARE UNIT	1,141,213	1,073,169	2,214,382	0	2,214,382 31.00
40.00	04000	SUBPROVIDER - IPF	1,131,514	621,492	1,753,006	0	1,753,006 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
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	1,537,471	4,566,072	6,103,543	-1,852,933	4,250,610 50.00
51.00	05100	RECOVERY ROOM	219,272	29,244	248,516	0	248,516 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174,523	75,406	249,929	-249,929	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,723,910	1,723,910	0	1,723,910 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,804,040	1,639,476	3,443,516	1,150,441	4,593,957 54.00
54.01	05401	ULTRA-SOUND	115,078	31,335	146,413	-146,413	0 54.01
56.00	05600	RADIOISOTOPE	69,956	84,039	153,995	-153,995	0 56.00
57.00	05700	CT SCAN	302,185	333,517	635,702	-635,702	0 57.00
58.00	05800	MRI	128,338	86,513	214,851	-214,851	0 58.00
60.00	06000	LABORATORY	2,645,271	2,846,186	5,491,457	-29,878	5,461,579 60.00
65.00	06500	RESPIRATORY THERAPY	633,182	428,326	1,061,508	-72,466	989,042 65.00
66.00	06600	PHYSICAL THERAPY	903,708	201,501	1,105,209	250,729	1,355,938 66.00
67.00	06700	OCCUPATIONAL THERAPY	139,998	11,215	151,213	-151,213	0 67.00
68.00	06800	SPEECH PATHOLOGY	93,640	7,151	100,791	-100,791	0 68.00
69.00	06900	ELECTROCARDIOLOGY	801,110	1,034,160	1,835,270	-304,026	1,531,244 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	532,406	532,406 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,575,137	1,575,137 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,096,781	1,096,781 73.00
74.00	07400	RENAL DIALYSIS	0	187,627	187,627	0	187,627 74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	200,976	191,772	392,748	0	392,748 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	740,881	194,493	935,374	-724,058	211,316 76.02
76.03	03950	WOUND CARE	154,008	83,016	237,024	-2,777	234,247 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	110,078	84,578	194,656	-6,000	188,656 90.00
91.00	09100	EMERGENCY	2,321,142	4,467,014	6,788,156	-8,041	6,780,115 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,649,358	72,867,910	102,517,268	-355,678	102,161,590 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	247,946	247,946	0	247,946 192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	350,198	350,198 194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	970	-44	926	5,480	6,406 194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0 194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	0	0	0	0 194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	29,650,328	73,115,812	102,766,140	0	102,766,140 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0125

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

Worksheet A

Date/Time Prepared:
5/22/2022 10:34 am

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	174,068	2,606,536	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	128,947	3,182,346	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,931	4,640,975	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,936,527	20,158,244	5.00
7.00	00700	OPERATION OF PLANT	0	4,761,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,768	8.00
9.00	00900	HOUSEKEEPING	0	1,980,418	9.00
10.00	01000	DIETARY	0	1,568,474	10.00
11.00	01100	CAFETERIA	-192,554	175,536	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,019,690	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	329,956	14.00
15.00	01500	PHARMACY	0	1,751,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-508	269,724	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,135,146	9,171,826	30.00
31.00	03100	INTENSIVE CARE UNIT	-689,687	1,524,695	31.00
40.00	04000	SUBPROVIDER - IPF	-242,755	1,510,251	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
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	-353,676	3,896,934	50.00
51.00	05100	RECOVERY ROOM	0	248,516	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,618,195	105,715	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-194,471	4,399,486	54.00
54.01	05401	ULTRA-SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	-16,354	5,445,225	60.00
65.00	06500	RESPIRATORY THERAPY	0	989,042	65.00
66.00	06600	PHYSICAL THERAPY	0	1,355,938	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	1,531,244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	532,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,575,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,096,781	73.00
74.00	07400	RENAL DIALYSIS	0	187,627	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	-77,500	315,248	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-58,359	152,957	76.02
76.03	03950	WOUND CARE	0	234,247	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	188,656	90.00
91.00	09100	EMERGENCY	-2,771,054	4,009,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-19,990,702	82,170,888	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	247,946	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	350,198	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	6,406	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-19,990,702	82,775,438	200.00

RECLASSIFICATIONS

Provider CCN: 14-0125

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

Worksheet A-6

Date/Time Prepared:
5/22/2022 10:34 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS OF EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,249,173		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
	0		0	4,249,173		
	B - RECLASS OF OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	76,833		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
	0		0	76,833		
	D - RECLASS OF OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	282,957		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,079,921		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,676		3.00
	0		0	1,378,554		
	E - RECLASS OF MARKETING DEPARTMENTS					
1.00	OTHER NONREIMB - MARKETING	194.01	107,512	242,686		1.00
	0		107,512	242,686		
	F - RECLASS OF MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	455,573		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,575,137		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	121,514		3.00
	0		0	2,152,224		
	G - RECLASS OF COST OF DRUGS/IV SOLUTION					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,096,781		1.00
	0		0	1,096,781		
	H - RECLASS OF PT, OT, AND SP COSTS					
1.00	PHYSICAL THERAPY	66.00	233,638	18,366		1.00
2.00		0.00	0	0		2.00
	0		233,638	18,366		
	I - RECLASS OF MISC DEPARTMENTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	612,728	107,605		1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	1,275		2.00
3.00	OTHER NONREIMB - SENIOR CIRCLE	194.02	0	5,480		3.00
	0		612,728	114,360		
	J - RECLASS OF OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	615,557	535,404		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
	0		615,557	535,404		
	K - RECLASS OF A PORTION OF DIETARY COST					
1.00	CAFETERIA	11.00	0	368,090		1.00
	0		0	368,090		
	M - OB/GYN COSTS					
1.00	ADULTS & PEDIATRICS	30.00	174,523	75,406		1.00
	0		174,523	75,406		
500.00	Grand Total: Increases		1,743,958	10,307,877		500.00

RECLASSIFICATIONS

Provider CCN: 14-0125

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

Worksheet A-6

Date/Time Prepared:
5/22/2022 10:34 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS OF EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,847,722	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	335,599	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	10,300	0		3.00
4.00	OPERATING ROOM	50.00	0	3,600	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	520	0		5.00
6.00	LABORATORY	60.00	0	29,614	0		6.00
7.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	5,000	0		7.00
8.00	WOUND CARE	76.03	0	2,777	0		8.00
9.00	CLINIC	90.00	0	6,000	0		9.00
10.00	EMERGENCY	91.00	0	8,041	0		10.00
			0	4,249,173			
	B - RECLASS OF OXYGEN COSTS						
1.00	OPERATION OF PLANT	7.00	0	2,968	0		1.00
2.00	OPERATING ROOM	50.00	0	745	0		2.00
3.00	LABORATORY	60.00	0	264	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	72,466	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	390	0		5.00
			0	76,833			
	D - RECLASS OF OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,378,554	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
			0	1,378,554			
	E - RECLASS OF MARKETING DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	107,512	242,686	0		1.00
			107,512	242,686			
	F - RECLASS OF MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	1,848,588	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	303,636	0		2.00
3.00		0.00	0	0	0		3.00
			0	2,152,224			
	G - RECLASS OF COST OF DRUGS/IV SOLUTION						
1.00	PHARMACY	15.00	0	1,096,781	0		1.00
			0	1,096,781			
	H - RECLASS OF PT, OT, AND SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	139,998	11,215	0		1.00
2.00	SPEECH PATHOLOGY	68.00	93,640	7,151	0		2.00
			233,638	18,366			
	I - RECLASS OF MISC DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,480	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	1,275	0		2.00
3.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	612,728	107,605	0		3.00
			612,728	114,360			
	J - RECLASS OF OTHER RADIOLOGY COSTS						
1.00	ULTRA-SOUND	54.01	115,078	31,335	0		1.00
2.00	RADIOISOTOPE	56.00	69,956	84,039	0		2.00
3.00	CT SCAN	57.00	302,185	333,517	0		3.00
4.00	MRI	58.00	128,338	86,513	0		4.00
			615,557	535,404			
	K - RECLASS OF A PORTION OF DIETARY COST						
1.00	DIETARY	10.00	0	368,090	0		1.00
			0	368,090			
	M - OB/GYN COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	174,523	75,406	0		1.00
			174,523	75,406			
500.00	Grand Total: Decreases		1,743,958	10,307,877			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/22/2022 10:34 am

		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	3,312,385	0	0	0	175,234	1.00	
2.00	Land Improvements	2,969,295	0	0	0	2,695,245	2.00	
3.00	Buildings and Fixtures	4,168,576	19,691,709	0	19,691,709	1,338,192	3.00	
4.00	Building Improvements	34,714,167	0	0	0	31,945,694	4.00	
5.00	Fixed Equipment	8,642,908	0	0	0	7,793,673	5.00	
6.00	Movable Equipment	27,007,906	0	0	0	19,925,209	6.00	
7.00	HIT designated Assets	6,157,552	0	0	0	5,165,068	7.00	
8.00	Subtotal (sum of lines 1-7)	86,972,789	19,691,709	0	19,691,709	69,038,315	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	86,972,789	19,691,709	0	19,691,709	69,038,315	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,137,151	0				1.00	
2.00	Land Improvements	274,050	0				2.00	
3.00	Buildings and Fixtures	22,522,093	0				3.00	
4.00	Building Improvements	2,768,473	0				4.00	
5.00	Fixed Equipment	849,235	0				5.00	
6.00	Movable Equipment	7,082,697	0				6.00	
7.00	HIT designated Assets	992,484	0				7.00	
8.00	Subtotal (sum of lines 1-7)	37,626,183	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	37,626,183	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,069,590	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,037,723	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,107,313	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,069,590				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,037,723				2.00
3.00	Total (sum of lines 1-2)	0	4,107,313				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/22/2022 10:34 am

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	28,701,767	0	28,701,767	0.762814	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,924,415	0	8,924,415	0.237186	0	2.00
3.00	Total (sum of lines 1-2)	37,626,182	0	37,626,182	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	1,243,658	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,166,670	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,410,328	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	282,957	1,079,921	0	2,606,536	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,676	0	0	3,182,346	2.00
3.00	Total (sum of lines 1-2)	0	298,633	1,079,921	0	5,788,882	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0125

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

Worksheet A-8

Date/Time Prepared:
5/22/2022 10:34 am

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)	B	-310,092	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-71,929	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-26,659	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,157,197			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	273,232			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-192,554	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-508	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,786	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	5,668	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-9,254	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	PATIENT TRANSPORTATION	A	-5,520	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0125

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

Worksheet A-8

Date/Time Prepared:
5/22/2022 10:34 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description		Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.
		1.00	2.00	3.00	4.00	5.00
33.03	OTHER MISC REVENUE	B	-38,305	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.05	PATIENT PHONES WAGE COST	A	-30,885	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06	PATIENT PHONES BENEFIT COST	A	-6,931	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.06
33.07	PATIENT PHONES DEPRECIATION EXPENSE	A	-4,866	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.07
33.08	PATIENT TV DEPRECIATION	A	-7,131	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.08
33.09	MARKETING EXPENSE	A	-152,089	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.11	PHYSICIAN RECRUITING	A	-11,948	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12	LOBBYING EXPENSES	A	-47,836	ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-500	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 33.14
33.15	ILLINOIS PROVIDER TAX	B	-11,187,412	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.17	NON ALLOWABLE LEGAL FEES	A	-5,200	ADMINISTRATIVE & GENERAL	5.00	0 33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,990,702			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: 14-0125

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

Worksheet A-8-1

Date/Time Prepared:
5/22/2022 10:34 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	12,603	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	2,208,493	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	478,492	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	150,198	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	1,973,904	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	1,512,852	2,038,390 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	4,024,920 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,336,542	6,063,310	5.00

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

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

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

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

6.00	B	QHC, INC.	100.00	QHC, INC.	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: 14-0125

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

Worksheet A-8-1

Date/Time Prepared:
5/22/2022 10:34 am

	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	12,603	0		1.00
2.00	2,208,493	0		2.00
3.00	478,492	9		3.00
4.00	150,198	9		4.00
4.01	1,973,904	0		4.01
4.02	-525,538	0		4.02
4.03	-4,024,920	0		4.03
5.00	273,232			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	HOSPITAL MANAGEMENT		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: 14-0125

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

Worksheet A-8-2

Date/Time Prepared:
5/22/2022 10:34 am

	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,135,146	2,135,146	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	689,687	689,687	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	242,755	242,755	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	353,676	353,676	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	1,618,195	1,618,195	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	194,471	194,471	0	0	0	8.00
9.00	60.00	LABORATORY	16,354	16,354	0	0	0	9.00
10.00	76.01	SLEEP LAB	77,500	77,500	0	0	0	10.00
11.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	58,359	58,359	0	0	0	11.00
12.00	91.00	EMERGENCY	2,771,054	2,771,054	0	0	0	12.00
200.00			8,157,197	8,157,197	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	76.01	SLEEP LAB	0	0	0	0	0	10.00
11.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,135,146		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	689,687		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	242,755		4.00
5.00	43.00	NURSERY	0	0	0	0		5.00
6.00	50.00	OPERATING ROOM	0	0	0	353,676		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	1,618,195		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	194,471		8.00
9.00	60.00	LABORATORY	0	0	0	16,354		9.00
10.00	76.01	SLEEP LAB	0	0	0	77,500		10.00
11.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	58,359		11.00
12.00	91.00	EMERGENCY	0	0	0	2,771,054		12.00
200.00			0	0	0	8,157,197		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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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	2,606,536	2,606,536			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,182,346		3,182,346		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,640,975	9,211	13,974	4,664,160	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,158,244	273,978	415,685	659,601	5.00
7.00	00700	OPERATION OF PLANT	4,761,247	626,759	950,924	133,217	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	254,768	15,200	23,062	0	8.00
9.00	00900	HOUSEKEEPING	1,980,418	22,698	34,438	0	9.00
10.00	01000	DIETARY	1,568,474	33,698	51,127	0	10.00
11.00	01100	CAFETERIA	175,536	24,951	37,856	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,019,690	915	1,388	271,318	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	329,956	27,644	41,942	24,500	14.00
15.00	01500	PHARMACY	1,751,982	19,711	29,906	206,248	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	269,724	78,783	119,532	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,171,826	286,857	435,224	1,035,986	30.00
31.00	03100	INTENSIVE CARE UNIT	1,524,695	87,152	132,228	181,279	31.00
40.00	04000	SUBPROVIDER - IPF	1,510,251	45,323	68,765	179,739	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
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	3,896,934	144,491	219,224	244,224	50.00
51.00	05100	RECOVERY ROOM	248,516	6,236	9,461	34,831	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	105,715	1,983	3,009	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,399,486	103,436	156,935	384,348	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	5,445,225	35,157	53,341	420,196	60.00
65.00	06500	RESPIRATORY THERAPY	989,042	28,776	43,660	100,580	65.00
66.00	06600	PHYSICAL THERAPY	1,355,938	67,888	103,001	180,665	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	1,531,244	19,840	30,102	127,255	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	532,406	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,575,137	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,096,781	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	187,627	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	315,248	27,063	41,061	31,925	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	152,957	13,987	21,222	20,357	76.02
76.03	03950	WOUND CARE	234,247	10,992	16,678	24,464	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	188,656	33,839	51,341	17,486	90.00
91.00	09100	EMERGENCY	4,009,061	40,619	61,628	368,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,170,888	2,087,187	3,166,714	4,646,928	81,618,675
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,757	4,183	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	247,946	335,473	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	350,198	7,546	11,449	17,078	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	6,406	0	0	154	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB - IDLE SPACE	0	173,573	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	82,775,438	2,606,536	3,182,346	4,664,160	82,775,438

COST ALLOCATION - GENERAL SERVICE COSTS

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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	21,507,508					5.00
7.00	00700	OPERATION OF PLANT	2,271,982	8,744,129				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	102,865	111,924	507,819			8.00
9.00	00900	HOUSEKEEPING	715,263	167,129	0	2,919,946		9.00
10.00	01000	DIETARY	580,374	248,126	0	66,255	2,548,054	10.00
11.00	01100	CAFETERIA	83,668	183,720	0	49,057	0	11.00
13.00	01300	NURSING ADMINISTRATION	805,044	6,737	0	1,799	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,856	203,546	0	54,351	0	14.00
15.00	01500	PHARMACY	704,835	145,136	0	38,754	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	164,300	580,099	0	154,899	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,836,842	2,112,187	340,347	564,000	1,792,618	30.00
31.00	03100	INTENSIVE CARE UNIT	675,876	641,715	21,610	171,352	151,985	31.00
40.00	04000	SUBPROVIDER - IPF	633,304	333,724	54,023	89,111	344,852	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	1,581,391	1,063,915	37,816	284,088	4,489	50.00
51.00	05100	RECOVERY ROOM	104,976	45,915	0	12,260	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,863	14,603	0	3,899	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,770,718	761,622	0	203,370	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	2,090,064	258,870	0	69,124	0	60.00
65.00	06500	RESPIRATORY THERAPY	407,929	211,887	0	56,578	0	65.00
66.00	06600	PHYSICAL THERAPY	599,398	499,873	0	133,477	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	599,731	146,086	0	39,008	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	552,936	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	385,014	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	65,865	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	145,786	199,273	0	53,210	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	73,200	102,990	0	27,501	0	76.02
76.03	03950	WOUND CARE	100,531	80,938	0	21,612	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	102,266	249,165	0	66,532	0	90.00
91.00	09100	EMERGENCY	1,572,665	299,087	54,023	79,863	45,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,101,438	8,668,267	507,819	2,240,100	2,339,604	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,436	20,301	0	5,421	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	204,803	0	0	659,589	208,450	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	135,597	55,561	0	14,836	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	2,303	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	60,931	0	0	0	0	194.04
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)	21,507,508	8,744,129	507,819	2,919,946	2,548,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0125

Period:
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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	554,788					11.00
13.00	01300	NURSING ADMINISTRATION	32,470	3,139,361				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,822	0	836,617			14.00
15.00	01500	PHARMACY	25,310	272,253	17,319	3,211,454		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	357	0	1,367,694	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	163,934	1,367,513	40,158	0	217,097	30.00
31.00	03100	INTENSIVE CARE UNIT	18,710	239,293	26,091	0	27,754	31.00
40.00	04000	SUBPROVIDER - IPF	23,037	237,259	1,743	0	36,134	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	31,520	322,382	271,342	0	136,778	50.00
51.00	05100	RECOVERY ROOM	3,673	45,978	1,924	0	18,081	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	25,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,157	0	20,110	0	118,711	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	70,886	0	51,797	0	279,511	60.00
65.00	06500	RESPIRATORY THERAPY	14,741	0	15,904	0	41,488	65.00
66.00	06600	PHYSICAL THERAPY	24,952	0	1,740	0	26,931	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	18,383	167,979	65,102	0	76,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	40,662	0	8,535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	178,934	0	19,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,211,454	41,399	73.00
74.00	07400	RENAL DIALYSIS	0	0	74	0	6,491	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,592	0	3,458	0	2,000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,950	0	85	0	4,943	76.02
76.03	03950	WOUND CARE	4,514	0	11,858	0	2,936	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,631	0	0	0	9,621	90.00
91.00	09100	EMERGENCY	41,965	486,704	86,924	0	268,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	553,247	3,139,361	835,582	3,211,454	1,367,694	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	1,510	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	31	0	1,035	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	0	0	0	0	194.04
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)	554,788	3,139,361	836,617	3,211,454	1,367,694	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	21,364,589	0	21,364,589	30.00
31.00	03100	INTENSIVE CARE UNIT	3,899,740	0	3,899,740	31.00
40.00	04000	SUBPROVIDER - IPF	3,557,265	0	3,557,265	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
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	8,238,594	0	8,238,594	50.00
51.00	05100	RECOVERY ROOM	531,851	0	531,851	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	193,299	0	193,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,979,893	0	7,979,893	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	8,774,171	0	8,774,171	60.00
65.00	06500	RESPIRATORY THERAPY	1,910,585	0	1,910,585	65.00
66.00	06600	PHYSICAL THERAPY	2,993,863	0	2,993,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,821,513	0	2,821,513	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	768,499	0	768,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,030	0	2,326,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,734,648	0	4,734,648	73.00
74.00	07400	RENAL DIALYSIS	260,057	0	260,057	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	823,616	0	823,616	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,192	0	422,192	76.02
76.03	03950	WOUND CARE	508,770	0	508,770	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	721,537	0	721,537	90.00
91.00	09100	EMERGENCY	7,415,159	0	7,415,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,245,871	0	80,245,871	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,098	0	35,098	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,656,261	0	1,656,261	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	593,775	0	593,775	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	9,929	0	9,929	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	234,504	0	234,504	194.04
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)	82,775,438	0	82,775,438	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

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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	9,211	13,974	23,185	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	273,978	415,685	689,663	5.00
7.00	00700	OPERATION OF PLANT	0	626,759	950,924	1,577,683	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,200	23,062	38,262	8.00
9.00	00900	HOUSEKEEPING	0	22,698	34,438	57,136	9.00
10.00	01000	DIETARY	0	33,698	51,127	84,825	10.00
11.00	01100	CAFETERIA	0	24,951	37,856	62,807	11.00
13.00	01300	NURSING ADMINISTRATION	0	915	1,388	2,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,644	41,942	69,586	14.00
15.00	01500	PHARMACY	0	19,711	29,906	49,617	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,783	119,532	198,315	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	286,857	435,224	722,081	30.00
31.00	03100	INTENSIVE CARE UNIT	0	87,152	132,228	219,380	31.00
40.00	04000	SUBPROVIDER - IPF	0	45,323	68,765	114,088	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
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	144,491	219,224	363,715	50.00
51.00	05100	RECOVERY ROOM	0	6,236	9,461	15,697	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,983	3,009	4,992	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,436	156,935	260,371	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	35,157	53,341	88,498	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,776	43,660	72,436	65.00
66.00	06600	PHYSICAL THERAPY	0	67,888	103,001	170,889	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	19,840	30,102	49,942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	27,063	41,061	68,124	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	13,987	21,222	35,209	76.02
76.03	03950	WOUND CARE	0	10,992	16,678	27,670	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	33,839	51,341	85,180	90.00
91.00	09100	EMERGENCY	0	40,619	61,628	102,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,087,187	3,166,714	5,253,901	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,757	4,183	6,940	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	335,473	0	335,473	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	7,546	11,449	18,995	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	173,573	0	173,573	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,606,536	3,182,346	5,788,882	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	692,943					5.00
7.00	00700	OPERATION OF PLANT	73,200	1,651,546				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,314	21,140	62,716			8.00
9.00	00900	HOUSEKEEPING	23,045	31,566	0	111,747		9.00
10.00	01000	DIETARY	18,699	46,865	0	2,536	152,925	10.00
11.00	01100	CAFETERIA	2,696	34,700	0	1,877	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,937	1,273	0	69	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,796	38,445	0	2,080	0	14.00
15.00	01500	PHARMACY	22,709	27,413	0	1,483	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,294	109,566	0	5,928	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	123,619	398,939	42,033	21,584	107,587	30.00
31.00	03100	INTENSIVE CARE UNIT	21,776	121,204	2,669	6,558	9,122	31.00
40.00	04000	SUBPROVIDER - IPF	20,404	63,032	6,672	3,410	20,697	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	50,950	200,947	4,670	10,872	269	50.00
51.00	05100	RECOVERY ROOM	3,382	8,672	0	469	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,252	2,758	0	149	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,050	143,851	0	7,783	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	67,339	48,894	0	2,645	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,143	40,020	0	2,165	0	65.00
66.00	06600	PHYSICAL THERAPY	19,312	94,413	0	5,108	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	19,322	27,592	0	1,493	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,022	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,815	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,405	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,122	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,697	37,638	0	2,036	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,358	19,452	0	1,052	0	76.02
76.03	03950	WOUND CARE	3,239	15,287	0	827	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,295	47,061	0	2,546	0	90.00
91.00	09100	EMERGENCY	50,669	56,490	6,672	3,056	2,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	679,861	1,637,218	62,716	85,726	140,415	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78	3,834	0	207	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,598	0	0	25,246	12,510	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	4,369	10,494	0	568	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	74	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	1,963	0	0	0	0	194.04
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)	692,943	1,651,546	62,716	111,747	152,925	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
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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	102,080					11.00
13.00	01300	NURSING ADMINISTRATION	5,974	36,905				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,071	0	116,100			14.00
15.00	01500	PHARMACY	4,657	3,201	2,403	112,509		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	50	0	319,153	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,163	16,074	5,573	0	50,687	30.00
31.00	03100	INTENSIVE CARE UNIT	3,443	2,813	3,621	0	6,480	31.00
40.00	04000	SUBPROVIDER - IPF	4,239	2,789	242	0	8,436	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	5,800	3,790	37,654	0	31,935	50.00
51.00	05100	RECOVERY ROOM	676	541	267	0	4,222	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	5,890	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,253	0	2,791	0	27,716	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	13,043	0	7,188	0	65,087	60.00
65.00	06500	RESPIRATORY THERAPY	2,712	0	2,207	0	9,686	65.00
66.00	06600	PHYSICAL THERAPY	4,591	0	241	0	6,288	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	3,382	1,975	9,034	0	17,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,643	0	1,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,831	0	4,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	112,509	9,666	73.00
74.00	07400	RENAL DIALYSIS	0	0	10	0	1,515	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	845	0	480	0	467	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	911	0	12	0	1,154	76.02
76.03	03950	WOUND CARE	831	0	1,646	0	685	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	484	0	0	0	2,246	90.00
91.00	09100	EMERGENCY	7,721	5,722	12,063	0	62,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,796	36,905	115,956	112,509	319,153	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	278	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	6	0	144	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	0	0	0	0	194.04
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)	102,080	36,905	116,100	112,509	319,153	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	1,523,479	0	1,523,479	30.00
31.00	03100	INTENSIVE CARE UNIT	397,968	0	397,968	31.00
40.00	04000	SUBPROVIDER - IPF	244,903	0	244,903	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
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	711,817	0	711,817	50.00
51.00	05100	RECOVERY ROOM	34,099	0	34,099	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,041	0	15,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	512,726	0	512,726	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	294,784	0	294,784	60.00
65.00	06500	RESPIRATORY THERAPY	142,869	0	142,869	65.00
66.00	06600	PHYSICAL THERAPY	301,741	0	301,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	131,300	0	131,300	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,658	0	13,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,088	0	47,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,580	0	134,580	73.00
74.00	07400	RENAL DIALYSIS	3,647	0	3,647	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	114,446	0	114,446	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,249	0	60,249	76.02
76.03	03950	WOUND CARE	50,307	0	50,307	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	140,899	0	140,899	90.00
91.00	09100	EMERGENCY	311,845	0	311,845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,187,446	0	5,187,446	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,059	0	11,059	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	379,827	0	379,827	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	34,789	0	34,789	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	225	0	225	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	175,536	0	175,536	194.04
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)	5,788,882	0	5,788,882	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	646,643				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		520,356			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,285	2,285	29,362,341		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,970	67,970	4,152,406	-21,507,508	5.00
7.00	00700	OPERATION OF PLANT	155,489	155,489	838,647	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	3,771	0	0	8.00
9.00	00900	HOUSEKEEPING	5,631	5,631	0	0	9.00
10.00	01000	DIETARY	8,360	8,360	0	0	10.00
11.00	01100	CAFETERIA	6,190	6,190	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	227	227	1,708,037	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	6,858	154,233	0	14.00
15.00	01500	PHARMACY	4,890	4,890	1,298,401	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	19,545	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	71,165	71,165	6,521,802	0	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	21,621	1,141,213	0	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	11,244	1,131,514	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
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	35,846	35,846	1,537,471	0	50.00
51.00	05100	RECOVERY ROOM	1,547	1,547	219,272	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	492	492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,661	25,661	2,419,597	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	8,722	8,722	2,645,271	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	7,139	633,182	0	65.00
66.00	06600	PHYSICAL THERAPY	16,842	16,842	1,137,346	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	4,922	4,922	801,110	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	6,714	200,976	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	3,470	128,153	0	76.02
76.03	03950	WOUND CARE	2,727	2,727	154,008	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,395	8,395	110,078	0	90.00
91.00	09100	EMERGENCY	10,077	10,077	2,321,142	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	517,800	517,800	29,253,859	-21,507,508	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	684	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,226	0	0	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	1,872	1,872	107,512	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	970	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	43,061	0	0	0	194.04
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)	2,606,536	3,182,346	4,664,160	21,507,508	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.030873	6.115709	0.158848	0.351040	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,185	692,943	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000790	0.011310	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 10:34 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0125

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	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	294,612					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	338,976				8.00
9.00	00900	HOUSEKEEPING	5,631	0	368,436			9.00
10.00	01000	DIETARY	8,360	0	8,360	79,467		10.00
11.00	01100	CAFETERIA	6,190	0	6,190	0	35,642	11.00
13.00	01300	NURSING ADMINISTRATION	227	0	227	0	2,086	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	0	6,858	0	374	14.00
15.00	01500	PHARMACY	4,890	0	4,890	0	1,626	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	0	19,545	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,165	227,186	71,165	55,907	10,532	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	14,425	21,621	4,740	1,202	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	36,061	11,244	10,755	1,480	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	35,846	25,243	35,846	140	2,025	50.00
51.00	05100	RECOVERY ROOM	1,547	0	1,547	0	236	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	492	0	492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,661	0	25,661	0	3,929	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	8,722	0	8,722	0	4,554	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	0	7,139	0	947	65.00
66.00	06600	PHYSICAL THERAPY	16,842	0	16,842	0	1,603	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	4,922	0	4,922	0	1,181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	0	6,714	0	295	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	0	3,470	0	318	76.02
76.03	03950	WOUND CARE	2,727	0	2,727	0	290	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8,395	0	8,395	0	169	90.00
91.00	09100	EMERGENCY	10,077	36,061	10,077	1,424	2,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	292,056	338,976	282,654	72,966	35,543	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	0	684	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	83,226	6,501	0	192.00
194.00	07950	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	1,872	0	1,872	0	97	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	2	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	0	0	0	0	194.04
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)	8,744,129	507,819	2,919,946	2,548,054	554,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.680152	1.498097	7.925246	32.064303	15.565569	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,651,546	62,716	111,747	152,925	102,080	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.605834	0.185016	0.303301	1.924384	2.864037	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: 14-0125

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

Worksheet B-1

Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description			NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQ S)	PHARMACY (COSTED REQ S)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			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	14,971,925				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,039,913			14.00
15.00	01500	PHARMACY	1,298,401	104,334	1,096,781		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,150	0	740,792,458	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,521,802	241,918	0	117,603,953	30.00
31.00	03100	INTENSIVE CARE UNIT	1,141,213	157,177	0	15,034,498	31.00
40.00	04000	SUBPROVIDER - IPF	1,131,514	10,502	0	19,574,007	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
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	1,537,471	1,634,594	0	74,094,021	50.00
51.00	05100	RECOVERY ROOM	219,272	11,592	0	9,794,911	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,666,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,148	0	64,307,161	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	312,033	0	151,310,867	60.00
65.00	06500	RESPIRATORY THERAPY	0	95,808	0	22,474,378	65.00
66.00	06600	PHYSICAL THERAPY	0	10,480	0	14,589,012	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	801,110	392,187	0	41,594,216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	244,952	0	4,623,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,077,931	0	10,305,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,096,781	22,426,296	73.00
74.00	07400	RENAL DIALYSIS	0	443	0	3,516,003	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	20,830	0	1,083,680	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	515	0	2,677,813	76.02
76.03	03950	WOUND CARE	0	71,437	0	1,590,380	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	5,212,029	90.00
91.00	09100	EMERGENCY	2,321,142	523,647	0	145,314,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,971,925	5,033,678	1,096,781	740,792,458	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	OTHER NONREIMB - NONPAID WORKERS	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	6,235	0	0	194.02
194.03	07953	OTHER NONREIMB - INDUSTRIAL MEDICINE	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB = IDLE SPACE	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,139,361	836,617	3,211,454	1,367,694	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.209683	0.165998	2.928072	0.001846	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,905	116,100	112,509	319,153	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002465	0.023036	0.102581	0.000431	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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 10:34 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,364,589		21,364,589	0	21,364,589	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,899,740		3,899,740	0	3,899,740	31.00	
40.00	04000	SUBPROVIDER - IPF	3,557,265		3,557,265	0	3,557,265	40.00	
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00	
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	8,238,594		8,238,594	0	8,238,594	50.00	
51.00	05100	RECOVERY ROOM	531,851		531,851	0	531,851	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	193,299		193,299	0	193,299	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,979,893		7,979,893	0	7,979,893	54.00	
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00	
57.00	05700	CT SCAN	0		0	0	0	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	8,774,171		8,774,171	0	8,774,171	60.00	
65.00	06500	RESPIRATORY THERAPY	1,910,585	0	1,910,585	0	1,910,585	65.00	
66.00	06600	PHYSICAL THERAPY	2,993,863	0	2,993,863	0	2,993,863	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	2,821,513		2,821,513	0	2,821,513	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	768,499		768,499	0	768,499	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,030		2,326,030	0	2,326,030	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,734,648		4,734,648	0	4,734,648	73.00	
74.00	07400	RENAL DIALYSIS	260,057		260,057	0	260,057	74.00	
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00	
76.01	03610	SLEEP LAB	823,616		823,616	0	823,616	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,192		422,192	0	422,192	76.02	
76.03	03950	WOUND CARE	508,770		508,770	0	508,770	76.03	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	721,537		721,537	0	721,537	90.00	
91.00	09100	EMERGENCY	7,415,159		7,415,159	0	7,415,159	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,285,969		2,285,969	0	2,285,969	92.00	
200.00		Subtotal (see instructions)	82,531,840	0	82,531,840	0	82,531,840	200.00	
201.00		Less Observation Beds	2,285,969		2,285,969	0	2,285,969	201.00	
202.00		Total (see instructions)	80,245,871	0	80,245,871	0	80,245,871	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 10:34 am

			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	108,335,751		108,335,751			30.00
31.00	03100	INTENSIVE CARE UNIT	15,034,498		15,034,498			31.00
40.00	04000	SUBPROVIDER - IPF	19,574,007		19,574,007			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
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	14,292,521	59,801,500	74,094,021	0.111191	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,472,326	8,322,585	9,794,911	0.054299	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,783,095	10,882,924	13,666,019	0.014144	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,630,979	54,676,182	64,307,161	0.124090	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	36,600,896	114,709,971	151,310,867	0.057988	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	17,708,537	4,765,841	22,474,378	0.085012	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,262,870	12,326,142	14,589,012	0.205214	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	15,996,739	25,597,477	41,594,216	0.067834	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,330,321	293,230	4,623,551	0.166214	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,352,077	6,953,111	10,305,188	0.225714	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,191,149	7,235,147	22,426,296	0.211120	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,347,653	168,350	3,516,003	0.073964	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,083,680	1,083,680	0.760018	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,419,146	258,667	2,677,813	0.157663	0.000000	76.02
76.03	03950	WOUND CARE	978	1,589,402	1,590,380	0.319905	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,330	5,208,699	5,212,029	0.138437	0.000000	90.00
91.00	09100	EMERGENCY	30,899,192	114,415,283	145,314,475	0.051028	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,312,036	5,956,166	9,268,202	0.246646	0.000000	92.00
200.00		Subtotal (see instructions)	306,548,101	434,244,357	740,792,458			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	306,548,101	434,244,357	740,792,458			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111191			50.00
51.00	05100	RECOVERY ROOM	0.054299			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.014144			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124090			54.00
54.01	05401	ULTRA-SOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.057988			60.00
65.00	06500	RESPIRATORY THERAPY	0.085012			65.00
66.00	06600	PHYSICAL THERAPY	0.205214			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.067834			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.166214			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225714			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211120			73.00
74.00	07400	RENAL DIALYSIS	0.073964			74.00
76.00	03020	ACUPUNCTURE	0.000000			76.00
76.01	03610	SLEEP LAB	0.760018			76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.157663			76.02
76.03	03950	WOUND CARE	0.319905			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.138437			90.00
91.00	09100	EMERGENCY	0.051028			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.246646			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 10:34 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,364,589		21,364,589	0	21,364,589	30.00
31.00	03100	INTENSIVE CARE UNIT	3,899,740		3,899,740	0	3,899,740	31.00
40.00	04000	SUBPROVIDER - IPF	3,557,265		3,557,265	0	3,557,265	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
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	8,238,594		8,238,594	0	8,238,594	50.00
51.00	05100	RECOVERY ROOM	531,851		531,851	0	531,851	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	193,299		193,299	0	193,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,979,893		7,979,893	0	7,979,893	54.00
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	8,774,171		8,774,171	0	8,774,171	60.00
65.00	06500	RESPIRATORY THERAPY	1,910,585	0	1,910,585	0	1,910,585	65.00
66.00	06600	PHYSICAL THERAPY	2,993,863	0	2,993,863	0	2,993,863	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	2,821,513		2,821,513	0	2,821,513	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	768,499		768,499	0	768,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,030		2,326,030	0	2,326,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,734,648		4,734,648	0	4,734,648	73.00
74.00	07400	RENAL DIALYSIS	260,057		260,057	0	260,057	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	823,616		823,616	0	823,616	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,192		422,192	0	422,192	76.02
76.03	03950	WOUND CARE	508,770		508,770	0	508,770	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	721,537		721,537	0	721,537	90.00
91.00	09100	EMERGENCY	7,415,159		7,415,159	0	7,415,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,285,969		2,285,969	0	2,285,969	92.00
200.00		Subtotal (see instructions)	82,531,840	0	82,531,840	0	82,531,840	200.00
201.00		Less Observation Beds	2,285,969		2,285,969	0	2,285,969	201.00
202.00		Total (see instructions)	80,245,871	0	80,245,871	0	80,245,871	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 10:34 am

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108,335,751		108,335,751			30.00	
31.00	03100	INTENSIVE CARE UNIT	15,034,498		15,034,498			31.00	
40.00	04000	SUBPROVIDER - IPF	19,574,007		19,574,007			40.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
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	14,292,521	59,801,500	74,094,021	0.111191	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,472,326	8,322,585	9,794,911	0.054299	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,783,095	10,882,924	13,666,019	0.014144	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,630,979	54,676,182	64,307,161	0.124090	0.000000	54.00	
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	36,600,896	114,709,971	151,310,867	0.057988	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	17,708,537	4,765,841	22,474,378	0.085012	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	2,262,870	12,326,142	14,589,012	0.205214	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	15,996,739	25,597,477	41,594,216	0.067834	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,330,321	293,230	4,623,551	0.166214	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,352,077	6,953,111	10,305,188	0.225714	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	15,191,149	7,235,147	22,426,296	0.211120	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	3,347,653	168,350	3,516,003	0.073964	0.000000	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.01	03610	SLEEP LAB	0	1,083,680	1,083,680	0.760018	0.000000	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,419,146	258,667	2,677,813	0.157663	0.000000	76.02	
76.03	03950	WOUND CARE	978	1,589,402	1,590,380	0.319905	0.000000	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,330	5,208,699	5,212,029	0.138437	0.000000	90.00	
91.00	09100	EMERGENCY	30,899,192	114,415,283	145,314,475	0.051028	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,312,036	5,956,166	9,268,202	0.246646	0.000000	92.00	
200.00		Subtotal (see instructions)	306,548,101	434,244,357	740,792,458			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	306,548,101	434,244,357	740,792,458			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111191			50.00
51.00	05100	RECOVERY ROOM	0.054299			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.014144			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124090			54.00
54.01	05401	ULTRA-SOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.057988			60.00
65.00	06500	RESPIRATORY THERAPY	0.085012			65.00
66.00	06600	PHYSICAL THERAPY	0.205214			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.067834			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.166214			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225714			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211120			73.00
74.00	07400	RENAL DIALYSIS	0.073964			74.00
76.00	03020	ACUPUNCTURE	0.000000			76.00
76.01	03610	SLEEP LAB	0.760018			76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.157663			76.02
76.03	03950	WOUND CARE	0.319905			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.138437			90.00
91.00	09100	EMERGENCY	0.051028			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.246646			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0125

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

Worksheet C
Part II
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,238,594	711,817	7,526,777	0	0 50.00
51.00	05100	RECOVERY ROOM	531,851	34,099	497,752	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	193,299	15,041	178,258	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,979,893	512,726	7,467,167	0	0 54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0 54.01
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
60.00	06000	LABORATORY	8,774,171	294,784	8,479,387	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	1,910,585	142,869	1,767,716	0	0 65.00
66.00	06600	PHYSICAL THERAPY	2,993,863	301,741	2,692,122	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	2,821,513	131,300	2,690,213	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	768,499	13,658	754,841	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,030	47,088	2,278,942	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,734,648	134,580	4,600,068	0	0 73.00
74.00	07400	RENAL DIALYSIS	260,057	3,647	256,410	0	0 74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	823,616	114,446	709,170	0	0 76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,192	60,249	361,943	0	0 76.02
76.03	03950	WOUND CARE	508,770	50,307	458,463	0	0 76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	721,537	140,899	580,638	0	0 90.00
91.00	09100	EMERGENCY	7,415,159	311,845	7,103,314	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,285,969	163,010	2,122,959	0	0 92.00
200.00		Subtotal (sum of lines 50 thru 199)	53,710,246	3,184,106	50,526,140	0	0 200.00
201.00		Less Observation Beds	2,285,969	163,010	2,122,959	0	0 201.00
202.00		Total (line 200 minus line 201)	51,424,277	3,021,096	48,403,181	0	0 202.00

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

Provider CCN: 14-0125

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

Worksheet C
Part II
Date/Time Prepared:
5/22/2022 10:34 am

				Title XIX		Hospital	PPS
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,238,594	74,094,021	0.111191		50.00
51.00	05100	RECOVERY ROOM	531,851	9,794,911	0.054299		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	193,299	13,666,019	0.014144		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,979,893	64,307,161	0.124090		54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	8,774,171	151,310,867	0.057988		60.00
65.00	06500	RESPIRATORY THERAPY	1,910,585	22,474,378	0.085012		65.00
66.00	06600	PHYSICAL THERAPY	2,993,863	14,589,012	0.205214		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,821,513	41,594,216	0.067834		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	768,499	4,623,551	0.166214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,326,030	10,305,188	0.225714		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,734,648	22,426,296	0.211120		73.00
74.00	07400	RENAL DIALYSIS	260,057	3,516,003	0.073964		74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	823,616	1,083,680	0.760018		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,192	2,677,813	0.157663		76.02
76.03	03950	WOUND CARE	508,770	1,590,380	0.319905		76.03
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	721,537	5,212,029	0.138437		90.00
91.00	09100	EMERGENCY	7,415,159	145,314,475	0.051028		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,285,969	9,268,202	0.246646		92.00
200.00		Subtotal (sum of lines 50 thru 199)	53,710,246	597,848,202			200.00
201.00		Less Observation Beds	2,285,969	0			201.00
202.00		Total (line 200 minus line 201)	51,424,277	597,848,202			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/22/2022 10:34 am

			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	1,523,479	0	1,523,479	19,692	77.37	30.00
31.00	INTENSIVE CARE UNIT	397,968		397,968	1,491	266.91	31.00
40.00	SUBPROVIDER - IPF	244,903	0	244,903	3,383	72.39	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
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)	2,166,350		2,166,350	24,566		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,157	166,887				30.00
31.00	INTENSIVE CARE UNIT	420	112,102				31.00
40.00	SUBPROVIDER - IPF	212	15,347				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	2,789	294,336				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/22/2022 10:34 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	711,817	74,094,021	0.009607	3,741,662	35,946	50.00
51.00	05100	RECOVERY ROOM	34,099	9,794,911	0.003481	374,010	1,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,041	13,666,019	0.001101	601,738	663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	512,726	64,307,161	0.007973	3,288,187	26,217	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	294,784	151,310,867	0.001948	11,950,575	23,280	60.00
65.00	06500	RESPIRATORY THERAPY	142,869	22,474,378	0.006357	5,819,796	36,996	65.00
66.00	06600	PHYSICAL THERAPY	301,741	14,589,012	0.020683	988,408	20,443	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	131,300	41,594,216	0.003157	5,284,504	16,683	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,658	4,623,551	0.002954	1,525,478	4,506	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,088	10,305,188	0.004569	1,107,198	5,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,580	22,426,296	0.006001	4,087,606	24,530	73.00
74.00	07400	RENAL DIALYSIS	3,647	3,516,003	0.001037	1,361,200	1,412	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	114,446	1,083,680	0.105609	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,249	2,677,813	0.022499	331,823	7,466	76.02
76.03	03950	WOUND CARE	50,307	1,590,380	0.031632	978	31	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	140,899	5,212,029	0.027033	0	0	90.00
91.00	09100	EMERGENCY	311,845	145,314,475	0.002146	7,836,335	16,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,010	9,268,202	0.017588	1,224,704	21,540	92.00
200.00		Total (lines 50 through 199)	3,184,106	597,848,202		49,524,202	242,891	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/22/2022 10:34 am		
					Title XVIII		Hospital		PPS		
Cost Center Description				Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
				1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description				Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
				4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	19,692	0.00	2,157	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	1,491	0.00	420	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	3,383	0.00	212	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0.00	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	24,566		2,789	0	0	200.00	
Cost Center Description				Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
				9.00							
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
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: 14-0125

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
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: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				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	74,094,021	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,794,911	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,666,019	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	64,307,161	0.000000	54.00
54.01	05401	ULTRA-SOUND		0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	151,310,867	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	22,474,378	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	14,589,012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	41,594,216	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,623,551	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,305,188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	22,426,296	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	3,516,003	0.000000	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	1,083,680	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	2,677,813	0.000000	76.02
76.03	03950	WOUND CARE		0	0	0	1,590,380	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,212,029	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	145,314,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	9,268,202	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	597,848,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/22/2022 10:34 am

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	3,741,662	0	8,376,424	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	374,010	0	1,050,963	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	601,738	0	1,663,088	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,288,187	0	8,040,084	0	54.00	
54.01	05401 ULTRA-SOUND	0.000000	0	0	0	0	54.01	
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800 MRI	0.000000	0	0	0	0	58.00	
60.00	06000 LABORATORY	0.000000	11,950,575	0	5,415,496	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	5,819,796	0	777,001	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	988,408	0	71,840	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	5,284,504	0	5,095,988	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,525,478	0	32,073	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,107,198	0	1,672,239	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4,087,606	0	894,936	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	1,361,200	0	43,290	0	74.00	
76.00	03020 ACUPUNCTURE	0.000000	0	0	0	0	76.00	
76.01	03610 SLEEP LAB	0.000000	0	0	138,528	0	76.01	
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	331,823	0	2,207	0	76.02	
76.03	03950 WOUND CARE	0.000000	978	0	423,723	0	76.03	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	0	0	120,998	0	90.00	
91.00	09100 EMERGENCY	0.000000	7,836,335	0	11,335,221	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,224,704	0	792,314	0	92.00	
200.00	Total (lines 50 through 199)		49,524,202	0	45,946,413	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/22/2022 10:34 am

			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	0.111191	8,376,424	0	0	931,383	50.00
51.00	05100	RECOVERY ROOM	0.054299	1,050,963	0	0	57,066	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014144	1,663,088	0	0	23,523	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124090	8,040,084	0	0	997,694	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.057988	5,415,496	0	0	314,034	60.00
65.00	06500	RESPIRATORY THERAPY	0.085012	777,001	0	0	66,054	65.00
66.00	06600	PHYSICAL THERAPY	0.205214	71,840	0	0	14,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067834	5,095,988	0	0	345,681	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.166214	32,073	0	0	5,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225714	1,672,239	0	0	377,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211120	894,936	5,985	0	188,939	73.00
74.00	07400	RENAL DIALYSIS	0.073964	43,290	0	0	3,202	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.760018	138,528	0	0	105,284	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.157663	2,207	0	0	348	76.02
76.03	03950	WOUND CARE	0.319905	423,723	0	0	135,551	76.03
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.138437	120,998	0	0	16,751	90.00
91.00	09100	EMERGENCY	0.051028	11,335,221	0	0	578,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.246646	792,314	0	0	195,421	92.00
200.00		Subtotal (see instructions)		45,946,413	5,985	0	4,356,867	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		45,946,413	5,985	0	4,356,867	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/22/2022 10:34 am
			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
51.00	05100	RECOVERY ROOM	0	0		51.00
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
54.01	05401	ULTRA-SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
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
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	1,264	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	1,264	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,264	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/22/2022 10:34 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		711,817	74,094,021	0.009607	0	0	50.00
51.00	05100	RECOVERY ROOM		34,099	9,794,911	0.003481	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY		15,041	13,666,019	0.001101	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		512,726	64,307,161	0.007973	12,262	98	54.00
54.01	05401	ULTRA-SOUND		0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE		0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN		0	0	0.000000	0	0	57.00
58.00	05800	MRI		0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY		294,784	151,310,867	0.001948	135,184	263	60.00
65.00	06500	RESPIRATORY THERAPY		142,869	22,474,378	0.006357	0	0	65.00
66.00	06600	PHYSICAL THERAPY		301,741	14,589,012	0.020683	5,632	116	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		131,300	41,594,216	0.003157	2,082	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		13,658	4,623,551	0.002954	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		47,088	10,305,188	0.004569	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		134,580	22,426,296	0.006001	71,287	428	73.00
74.00	07400	RENAL DIALYSIS		3,647	3,516,003	0.001037	0	0	74.00
76.00	03020	ACUPUNCTURE		0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB		114,446	1,083,680	0.105609	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		60,249	2,677,813	0.022499	19,130	430	76.02
76.03	03950	WOUND CARE		50,307	1,590,380	0.031632	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		140,899	5,212,029	0.027033	0	0	90.00
91.00	09100	EMERGENCY		311,845	145,314,475	0.002146	129,132	277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	9,268,202	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)		3,021,096	597,848,202		374,709	1,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
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
54.01	05401	ULTRA-SOUND		0	0	0	0	0	54.01
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
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
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	03020	ACUPUNCTURE		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	74,094,021	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,794,911	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,666,019	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	64,307,161	0.000000	54.00
54.01	05401	ULTRA-SOUND		0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	151,310,867	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	22,474,378	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	14,589,012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	41,594,216	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,623,551	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,305,188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	22,426,296	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	3,516,003	0.000000	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	1,083,680	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	2,677,813	0.000000	76.02
76.03	03950	WOUND CARE		0	0	0	1,590,380	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,212,029	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	145,314,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	9,268,202	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	597,848,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	12,262	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	135,184	0	2,726	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,632	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,082	0	1,388	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	71,287	0	141	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	19,130	0	736	0	76.02
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	129,132	0	16,825	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		374,709	0	21,816	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/22/2022 10:34 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.111191	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.054299	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014144	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124090	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.057988	2,726	0	0	0	158	60.00
65.00	06500	RESPIRATORY THERAPY	0.085012	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.205214	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067834	1,388	0	0	0	94	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.166214	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225714	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211120	141	0	422	30	73.00	
74.00	07400	RENAL DIALYSIS	0.073964	0	0	0	0	74.00	
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00	
76.01	03610	SLEEP LAB	0.760018	0	0	0	0	76.01	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.157663	736	0	0	116	76.02	
76.03	03950	WOUND CARE	0.319905	0	0	0	0	76.03	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.138437	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.051028	16,825	0	0	859	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.246646	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		21,816	0	422	1,257	200.00	
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00	
		Only Charges							
202.00		Net Charges (line 200 - line 201)		21,816	0	422	1,257	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/22/2022 10:34 am		
			Title XVIII		Subprovider - IPF		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
51.00	05100	RECOVERY ROOM	0	0					51.00
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
54.01	05401	ULTRA-SOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
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
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	89					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03020	ACUPUNCTURE	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0					76.02
76.03	03950	WOUND CARE	0	0					76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	89					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	89					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/22/2022 10:34 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,523,479	0	1,523,479	19,692	77.37	30.00
31.00	INTENSIVE CARE UNIT	397,968		397,968	1,491	266.91	31.00
40.00	SUBPROVIDER - IPF	244,903	0	244,903	3,383	72.39	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
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)	2,166,350		2,166,350	24,566		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	204	15,783				30.00
31.00	INTENSIVE CARE UNIT	56	14,947				31.00
40.00	SUBPROVIDER - IPF	1,021	73,910				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	1,281	104,640				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	711,817	74,094,021	0.009607	0	50.00
51.00	05100	RECOVERY ROOM	34,099	9,794,911	0.003481	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	15,041	13,666,019	0.001101	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	512,726	64,307,161	0.007973	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	294,784	151,310,867	0.001948	0	60.00
65.00	06500	RESPIRATORY THERAPY	142,869	22,474,378	0.006357	0	65.00
66.00	06600	PHYSICAL THERAPY	301,741	14,589,012	0.020683	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	131,300	41,594,216	0.003157	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,658	4,623,551	0.002954	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,088	10,305,188	0.004569	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,580	22,426,296	0.006001	0	73.00
74.00	07400	RENAL DIALYSIS	3,647	3,516,003	0.001037	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	76.00
76.01	03610	SLEEP LAB	114,446	1,083,680	0.105609	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,249	2,677,813	0.022499	0	76.02
76.03	03950	WOUND CARE	50,307	1,590,380	0.031632	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	140,899	5,212,029	0.027033	0	90.00
91.00	09100	EMERGENCY	311,845	145,314,475	0.002146	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,010	9,268,202	0.017588	0	92.00
200.00		Total (lines 50 through 199)	3,184,106	597,848,202		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/22/2022 10:34 am		
					Title XIX		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	19,692	0.00	204	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	1,491	0.00	56	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	3,383	0.00	1,021	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00			
43.00	04300	NURSERY	0	0	0	0.00	0	43.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00			
200.00		Total (lines 30 through 199)	0	0	24,566		1,281	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
31.00	03100	INTENSIVE CARE UNIT	0							31.00	
40.00	04000	SUBPROVIDER - IPF	0							40.00	
41.00	04100	SUBPROVIDER - IRF	0							41.00	
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: 14-0125

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
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: 14-0125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				Title XIX		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	74,094,021	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,794,911	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,666,019	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	64,307,161	0.000000	54.00
54.01	05401	ULTRA-SOUND		0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	151,310,867	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	22,474,378	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	14,589,012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	41,594,216	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,623,551	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,305,188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	22,426,296	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	3,516,003	0.000000	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	1,083,680	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	2,677,813	0.000000	76.02
76.03	03950	WOUND CARE		0	0	0	1,590,380	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,212,029	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	145,314,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	9,268,202	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	597,848,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0125

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/22/2022 10:34 am		
					Title XIX		Subprovider - IPF		PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)				
			1.00	2.00	3.00				4.00	5.00	
	ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	711,817	74,094,021	0.009607	0	0	50.00			
51.00	05100	RECOVERY ROOM	34,099	9,794,911	0.003481	0	0	51.00			
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00			
53.00	05300	ANESTHESIOLOGY	15,041	13,666,019	0.001101	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	512,726	64,307,161	0.007973	0	0	54.00			
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01			
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00			
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00			
58.00	05800	MRI	0	0	0.000000	0	0	58.00			
60.00	06000	LABORATORY	294,784	151,310,867	0.001948	0	0	60.00			
65.00	06500	RESPIRATORY THERAPY	142,869	22,474,378	0.006357	0	0	65.00			
66.00	06600	PHYSICAL THERAPY	301,741	14,589,012	0.020683	0	0	66.00			
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00			
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00			
69.00	06900	ELECTROCARDIOLOGY	131,300	41,594,216	0.003157	0	0	69.00			
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,658	4,623,551	0.002954	0	0	71.00			
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,088	10,305,188	0.004569	0	0	72.00			
73.00	07300	DRUGS CHARGED TO PATIENTS	134,580	22,426,296	0.006001	0	0	73.00			
74.00	07400	RENAL DIALYSIS	3,647	3,516,003	0.001037	0	0	74.00			
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00			
76.01	03610	SLEEP LAB	114,446	1,083,680	0.105609	0	0	76.01			
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,249	2,677,813	0.022499	0	0	76.02			
76.03	03950	WOUND CARE	50,307	1,590,380	0.031632	0	0	76.03			
	OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	140,899	5,212,029	0.027033	0	0	90.00			
91.00	09100	EMERGENCY	311,845	145,314,475	0.002146	0	0	91.00			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,268,202	0.000000	0	0	92.00			
200.00		Total (lines 50 through 199)	3,021,096	597,848,202		0	0	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
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
54.01	05401	ULTRA-SOUND		0	0	0	0	0	54.01
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
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
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	03020	ACUPUNCTURE		0	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03950	WOUND CARE		0	0	0	0	0	76.03
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: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	74,094,021	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,794,911	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	13,666,019	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	64,307,161	0.000000	54.00
54.01	05401	ULTRA-SOUND		0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	151,310,867	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	22,474,378	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	14,589,012	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	41,594,216	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,623,551	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,305,188	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	22,426,296	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	3,516,003	0.000000	74.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	1,083,680	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	2,677,813	0.000000	76.02
76.03	03950	WOUND CARE		0	0	0	1,590,380	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	5,212,029	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	145,314,475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	9,268,202	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	597,848,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/22/2022 10:34 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND		0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE		0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB		0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE		0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,692	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,692	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)		17,585	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,157	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)		21,364,589	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)		21,364,589	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)		21,364,589	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,084.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,340,216	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)		2,340,216	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:

5/22/2022 10:34 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,899,740	1,491	2,615.52	420	1,098,518	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,823,626	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,262,360	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)					278,989	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					242,891	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					521,880	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,740,480	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)					2,107	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,084.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,285,969	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
5/22/2022 10:34 am

		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	1,523,479	21,364,589	0.071309	2,285,969	163,010	90.00
91.00 Nursing Program cost	0	21,364,589	0.000000	2,285,969	0	91.00
92.00 Allied health cost	0	21,364,589	0.000000	2,285,969	0	92.00
93.00 All other Medical Education	0	21,364,589	0.000000	2,285,969	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,383	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,383	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)		3,383	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)		212	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)		3,557,265	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)		3,557,265	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)		3,557,265	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,051.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		222,920	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)		222,920	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					35,313	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					258,233	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)					15,347	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,619	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					16,966	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					241,267	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	244,903	3,557,265	0.068846	0	0	90.00
91.00	Nursing Program cost	0	3,557,265	0.000000	0	0	91.00
92.00	Allied health cost	0	3,557,265	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,557,265	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am
		Title XIX	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,692	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,692	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)		17,585	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)		204	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)		21,364,589	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)		21,364,589	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)		21,364,589	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,084.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		221,328	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)		221,328	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		Title XIX		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,899,740	1,491	2,615.52	56	146,469	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						367,797 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)						30,730 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						30,730 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						337,067 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)						2,107 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,084.94 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,285,969 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0125

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

Worksheet D-1

Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,523,479	21,364,589	0.071309	2,285,969	163,010
91.00	Nursing Program cost	0	21,364,589	0.000000	2,285,969	0
92.00	Allied health cost	0	21,364,589	0.000000	2,285,969	0
93.00	All other Medical Education	0	21,364,589	0.000000	2,285,969	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,383	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,383	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)		3,383	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,021	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)		3,557,265	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)		3,557,265	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)		3,557,265	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,051.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,073,592	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,073,592	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,073,592	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)					73,910	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					73,910	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					999,682	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0125 Component CCN: 14-S125		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/22/2022 10:34 am	
		Title XIX		Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	244,903	3,557,265	0.068846	0	0	90.00
91.00 Nursing Program cost	0	3,557,265	0.000000	0	0	91.00
92.00 Allied health cost	0	3,557,265	0.000000	0	0	92.00
93.00 All other Medical Education	0	3,557,265	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/22/2022 10:34 am	
			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		13,118,804		30.00
31.00	03100	INTENSIVE CARE UNIT		4,235,070		31.00
40.00	04000	SUBPROVIDER - IPF		16,225,286		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111191	3,741,662	416,039	50.00
51.00	05100	RECOVERY ROOM	0.054299	374,010	20,308	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014144	601,738	8,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124090	3,288,187	408,031	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.057988	11,950,575	692,990	60.00
65.00	06500	RESPIRATORY THERAPY	0.085012	5,819,796	494,752	65.00
66.00	06600	PHYSICAL THERAPY	0.205214	988,408	202,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067834	5,284,504	358,469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.166214	1,525,478	253,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.225714	1,107,198	249,910	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211120	4,087,606	862,975	73.00
74.00	07400	RENAL DIALYSIS	0.073964	1,361,200	100,680	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.760018	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.157663	331,823	52,316	76.02
76.03	03950	WOUND CARE	0.319905	978	313	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.138437	0	0	90.00
91.00	09100	EMERGENCY	0.051028	7,836,335	399,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.246646	1,224,704	302,068	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,524,202	4,823,626	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		49,524,202		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/22/2022 10:34 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		1,235,679		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.111191	0	0	50.00
51.00	05100 RECOVERY ROOM	0.054299	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.014144	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124090	12,262	1,522	54.00
54.01	05401 ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.057988	135,184	7,839	60.00
65.00	06500 RESPIRATORY THERAPY	0.085012	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.205214	5,632	1,156	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.067834	2,082	141	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.166214	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.225714	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211120	71,287	15,050	73.00
74.00	07400 RENAL DIALYSIS	0.073964	0	0	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.760018	0	0	76.01
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.157663	19,130	3,016	76.02
76.03	03950 WOUND CARE	0.319905	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.138437	0	0	90.00
91.00	09100 EMERGENCY	0.051028	129,132	6,589	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.246646	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		374,709	35,313	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)		374,709	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/22/2022 10:34 am	
		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)			6,380,883	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,873,107	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)			12,180	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			2,653	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)			282.23	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	or		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	\$		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			12.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)			49.54	31.00
32.00	Sum of lines 30 and 31			62.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)			40.58	33.00
34.00	Disproportionate share adjustment (see instructions)			837,368	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/22/2022 10:34 am	
		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)	788,718	636,685		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	589,918	160,480		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	750,398			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)		9,856,589		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			9,856,589	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			716,564	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			29,704	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)			10,602,857	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			10,602,857	61.00
62.00	Deductibles billed to program beneficiaries			990,476	62.00
63.00	Coinsurance billed to program beneficiaries			41,181	63.00
64.00	Allowable bad debts (see instructions)			541,394	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			351,906	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			383,027	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9,923,106	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)			-91,197	70.93
70.94	HRR adjustment amount (see instructions)			-74,336	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/22/2022 10:34 am
		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)		102,066	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,655,507	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		9,548,287	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		107,220	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,818,144	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/22/2022 10:34 am

		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	6,380,883	0	6,380,883		6,380,883
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,873,107	0		1,873,107	1,873,107
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	12,180	0	12,180		12,180
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	2,653	0		2,653	2,653
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	0.4058	0.4058	0.4058	0.4058	
11.00	Disproportionate share adjustment (see instructions)	34.00	837,368	0	647,341	190,027	837,368
11.01	Uncompensated care payments	36.00	750,398	0	589,918	160,480	750,398
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	9,856,589	0	7,630,322	2,226,267	9,856,589
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,856,589	0	7,630,322	2,226,267	9,856,589
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	716,564	0	535,950	180,614	716,564
17.00	Special add-on payments for new technologies	54.00	29,704	0	0	0	0
17.01	Net organ acquisition cost						

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/22/2022 10:34 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,166,272	2,406,881	10,573,153	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	629,546	0	470,866	158,680	629,546	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	2,407	0	1,800	607	2,407	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	0.1344	0.1344	0.1344	0.1344		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	84,611	0	63,284	21,327	84,611	25.00
26.00	Total prospective capital payments (see instructions)	12.00	716,564	0	535,950	180,614	716,564	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,264	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,356,867	2.00
3.00	OPPS payments		3,202,549	3.00
4.00	Outlier payment (see instructions)		12,192	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)		1,264	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,985	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)		5,985	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)		5,985	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,721	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)		1,264	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		3,214,741	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)		598,247	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,617,758	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,617,758	30.00
31.00	Primary payer payments		140	31.00
32.00	Subtotal (line 30 minus line 31)		2,617,618	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)		198,711	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		129,162	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		108,269	36.00
37.00	Subtotal (see instructions)		2,746,780	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-10	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,746,790	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,801,592	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-54,802	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		89	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,257	2.00
3.00	OPPS payments		1,209	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.00
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)		89	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		422	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)		422	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)		422	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		333	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)		89	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1,209	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)		135	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,163	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)		1,163	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,163	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,163	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,163	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		1,158	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)		5	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: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/22/2022 10:34 am

		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		9,317,787		2,713,292	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	12/10/2021	230,500	12/10/2021	88,300	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)		230,500		88,300	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)		9,548,287		2,801,592	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		107,220		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		54,802	6.02	
7.00	Total Medicare program liability (see instructions)		9,655,507		2,746,790	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prepared: 5/22/2022 10:34 am	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		189,305		1,158
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/10/2021	107,300		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		107,300		0
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)		296,605		1,158
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		5
6.02	SETTLEMENT TO PROGRAM		85,237		0
7.00	Total Medicare program liability (see instructions)		211,368		1,163
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0125 Component CCN: 14-S125	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			202,201 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			9.268493 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			202,201 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			202,201 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			202,201 18.00
19.00	Deductibles			25,000 19.00
20.00	Subtotal (line 18 minus line 19)			177,201 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			177,201 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			52,564 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			34,167 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,123 25.00
26.00	Subtotal (sum of lines 22 and 24)			211,368 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			211,368 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			296,605 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-85,237 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

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

Provider CCN: 14-0125

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

Worksheet G

Date/Time Prepared:
5/22/2022 10:34 am

		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	-572,344	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,193,782	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,352,301	0	0	0	6.00
7.00	Inventory	2,705,679	0	0	0	7.00
8.00	Prepaid expenses	1,505,472	0	0	0	8.00
9.00	Other current assets	56,169	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,536,457	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,137,151	0	0	0	12.00
13.00	Land improvements	274,050	0	0	0	13.00
14.00	Accumulated depreciation	-50,168	0	0	0	14.00
15.00	Buildings	20,418,274	0	0	0	15.00
16.00	Accumulated depreciation	-1,366,734	0	0	0	16.00
17.00	Leasehold improvements	2,787,650	0	0	0	17.00
18.00	Accumulated depreciation	-175,869	0	0	0	18.00
19.00	Fixed equipment	849,168	0	0	0	19.00
20.00	Accumulated depreciation	-241,919	0	0	0	20.00
21.00	Automobiles and trucks	4,232	0	0	0	21.00
22.00	Accumulated depreciation	-3,174	0	0	0	22.00
23.00	Major movable equipment	4,762,032	0	0	0	23.00
24.00	Accumulated depreciation	-1,893,276	0	0	0	24.00
25.00	Minor equipment depreciable	2,334,394	0	0	0	25.00
26.00	Accumulated depreciation	-897,481	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)	29,938,330	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,209,315	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,209,315	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,684,102	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,485,168	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,354,938	0	0	0	38.00
39.00	Payroll taxes payable	625,782	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	12,028,340	0	0	0	43.00
44.00	Other current liabilities	1,774,183	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,268,411	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,268,411	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,415,691				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,415,691	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,684,102	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0125

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

Worksheet G-1

Date/Time Prepared:
5/22/2022 10:34 am

		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		15,290,144		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		125,548				2.00
3.00	Total (sum of line 1 and line 2)		15,415,692		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)		15,415,692		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,415,691		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	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0125

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/22/2022 10:34 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	108,278,209		108,278,209	1.00
2.00	SUBPROVIDER - IPF	19,631,549		19,631,549	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	127,909,758		127,909,758	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,034,498		15,034,498	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,034,498		15,034,498	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	142,944,256		142,944,256	17.00
18.00	Ancillary services	129,389,287	308,664,209	438,053,496	18.00
19.00	Outpatient services	34,214,558	125,580,148	159,794,706	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	INDUSTRIAL MED, PRO FEES & LATE CHRG	0	5,768,272	5,768,272	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	306,548,101	440,012,629	746,560,730	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		102,766,140		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)		102,766,140		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0125

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

Worksheet G-3

Date/Time Prepared:
5/22/2022 10:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	746,560,730	1.00
2.00	Less contractual allowances and discounts on patients' accounts	648,810,384	2.00
3.00	Net patient revenues (line 1 minus line 2)	97,750,346	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	102,766,140	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,015,794	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	192,554	14.00
15.00	Revenue from rental of living quarters	310,092	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	509	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	2,786	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	4,632,678	23.00
24.00	OTHER INCOME	38,305	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	5,176,924	25.00
26.00	Total (line 5 plus line 25)	161,130	26.00
27.00	LOSS ON SALE OF FIXED ASSETS	35,582	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	35,582	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	125,548	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0125	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/22/2022 10:34 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		629,546	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,407	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)		52.26	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)		12.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		49.54	8.00
9.00	Sum of lines 7 and 8		62.26	9.00
10.00	Allowable disproportionate share percentage (see instructions)		13.44	10.00
11.00	Disproportionate share adjustment (see instructions)		84,611	11.00
12.00	Total prospective capital payments (see instructions)		716,564	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