

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: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet S Parts I-III Date/Time Prepared: 11/1/2021 6:08 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/1/2021	Time: 6:08 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MERCY HOSPITAL & MEDICAL CENTER (14-0158) for the cost reporting period beginning 07/01/2020 and ending 05/31/2021 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.

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

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-6,939,888	-254,952	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	52,908	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-6,886,980	-254,952	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: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 11/1/2021 6:08 pm		
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1.00		2.00		3.00		4.00					11/1/2021 8:00 pm
Hospital and Hospital Health Care Complex Address:											
1.00	Street:2525 SOUTH MICHIGAN AVENUE		PO Box:							1.00	
2.00	City: CHICAGO		State: IL		Zip Code: 60616-2477		County: COOK			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	MERCY HOSPITAL & MEDICAL CENTER		140158	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MERCY HOSPITAL & MEDICAL CENTER		14S158	16974	4	07/01/1984	N	P	O	4.00
5.00	Subprovider - IRF	MERCY HOSPITAL & MEDICAL CENTER		14T158	16974	5	07/01/1984	N	P	O	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
17.20	Hospital-Based (OPT) I										17.20
17.30	Hospital-Based (OOT) I										17.30
17.40	Hospital-Based (OSP) I										17.40
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:		To:		
							1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020		05/31/2021		20.00
21.00	Type of Control (see instructions)						1				21.00
					1.00		2.00		3.00		

Inpatient PPS Information		2100	2100	2100	
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 11/1/2021 6:08 pm	
		1.00	2.00	3.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
		1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,058	1,266	0	0	8,522	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	71	10	0	0	278	
		Urban/Rural S				Date of Geogr	
		1.00				2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:				Ending:	
		1.00				2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	0				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N				Y/N	
		1.00				2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N				39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y				40.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N				Y	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N				N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N				N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N				N	N
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y				Y	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-2
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

		V	XVIII	XIX		
		1.00	2.00	3.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
						1.00
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
62.01	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
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

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			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 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.							
64.00	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	
		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	
		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	
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

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			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.	Y			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)	Y	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 11/1/2021 6:08 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				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:			317,483	5,565,210	3,075,254	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 11/1/2021 6:08 pm
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		1.00	2.00	
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	HB1432	140.00
		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: TRINITY HEALTH	Contractor's Name: WPS		141.00
142.00	Street: 20555 VICTOR PKWY	PO Box:		142.00
143.00	City: LIVONIA	State: MI Zip Code: 48152		143.00
			1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
			1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00
		Part A	Part B	Title V
		1.00	2.00	3.00
	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)			Title XIX
				4.00
155.00	Hospital	N	N	N
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N
161.10	CORF		N	N
161.20	OUTPATIENT PHYSICAL THERAPY		N	N
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N
				1.00
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N	165.00
		Name	County	State
		0	1.00	2.00
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)			3.00
				4.00
				5.00
				0.00
				1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99
				169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 11/1/2021 6:08 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet S-2 Part II Date/Time Prepared: 11/1/2021 6:08 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					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)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	10/31/2017	N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			Y		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet S-2 Part II Date/Time Prepared: 11/1/2021 6:08 pm	
		Description		Y/N	Y/N		
		0		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions						22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions						24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.						25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.						26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						27.00
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions						29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.						30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.						31.00
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.						33.00
Provider-Based Physicians							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.						34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.						35.00
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?						36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.						37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.						38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.						39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.						40.00
				1.00		2.00	
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		CADDICK		41.00	
42.00	Enter the employer/company name of the cost report preparer.	SRGROUPLLC.COM				42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	708 466-7240		MICHAEL.CADDICK@SRGROUPLLC.COM		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Prepared: 11/1/2021 6:08 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE PRESIDENT		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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	132	52,392	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)		132	52,392	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	144,690	4,020	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
9.01 NURSERY INTENSIVE CARE CENTER	32.01	15	5,025	0.00	0	9.01
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
11.01 SURGICAL INTENSIVE CARE UNIT	34.01	0	0	0.00	0	11.01
11.02 SURGICAL INTENSIVE CARE UNIT	34.02	0	0	0.00	0	11.02
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		144,837	61,437	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	39	13,065		0	16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,360		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		144,892				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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,151	724	17,764			1.00
2.00	HMO and other (see instructions)	4,580	8,522				2.00
3.00	HMO IPF Subprovider	53	2,221				3.00
4.00	HMO IRF Subprovider	125	278				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)	5,151	724	17,764			7.00
8.00	INTENSIVE CARE UNIT	1,036	300	3,319			8.00
9.00	CORONARY CARE UNIT	0	0	0			9.00
9.01	NURSERY INTENSIVE CARE CENTER	0	500	1,264			9.01
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
11.01	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.01
11.02	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.02
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		500	1,532			13.00
14.00	Total (see instructions)	6,187	2,024	23,879	90.93	958.07	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	406	274	3,443	0.00	23.28	16.00
17.00	SUBPROVIDER - IRF	937	81	1,645	0.00	8.58	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				90.93	989.93	27.00
28.00	Observation Bed Days		0	2,369			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	300	564			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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,023	351	4,920	1.00
2.00 HMO and other (see instructions)			776	1,721		2.00
3.00 HMO IPF Subprovider				396		3.00
4.00 HMO IRF Subprovider				29		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
9.01 NURSERY INTENSIVE CARE CENTER						9.01
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 SURGICAL INTENSIVE CARE UNIT						11.01
11.02 SURGICAL INTENSIVE CARE UNIT						11.02
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,023	351	4,920	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	56	245	646	16.00
17.00 SUBPROVIDER - IRF	0.00	0	84	7	155	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	76,379,886	9,421,097	85,800,983	2,066,150.00	41.53
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		377,886	0	377,886	1,825.00	207.06
4.01	Physicians - Part A - Teaching		877,088	0	877,088	7,686.00	114.12
5.00	Physician and Non Physician-Part B		16,142,324	0	16,142,324	116,750.00	138.26
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,500,537	-994,764	505,773	17,114.00	29.55
7.01	Contracted interns and residents (in an approved programs)		1,799,370	0	1,799,370	54,526.00	33.00
8.00	Home office and/or related organization personnel		2,662,763	0	2,662,763	8,320.00	320.04
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,052,619	0	4,052,619	154,263.00	26.27
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,814,282	0	2,814,282	85,525.00	32.91
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	14.00
14.01	Home office salaries		6,905,660	0	6,905,660	126,957.00	54.39
14.02	Related organization salaries		0	0	0	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,422,676	0	15,422,676		17.00
18.00	Wage-related costs (other) (see instructions)						18.00
19.00	Excluded areas		1,209,412	0	1,209,412		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		28,975	0	28,975		22.00
22.01	Physician Part A - Teaching		101,884	0	101,884		22.01
23.00	Physician Part B		1,627,143	0	1,627,143		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		139,206	0	139,206		25.00
25.50	Home office wage-related (core)		1,816,976	0	1,816,976		25.50
25.51	Related organization wage-related (core)		0	0	0		25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	941,206	9,421,097	10,362,303	93,671.00	110.62	26.00
27.00	Administrative & General	5.00	8,616,774	0	8,616,774	314,714.00	27.38	27.00
28.00	Administrative & General under contract (see inst.)		1,186,259	0	1,186,259	8,645.00	137.22	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,089,609	0	2,089,609	57,450.00	36.37	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,487,546	0	1,487,546	91,199.00	16.31	32.00
33.00	Housekeeping under contract (see instructions)		656,197	0	656,197	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,298,394	0	1,298,394	0.00	0.00	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	1,927,089	0	1,927,089	37,176.00	51.84	38.00
39.00	Central Services and Supply	14.00	523,129	0	523,129	25,598.00	20.44	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,056,269	0	1,056,269	39,432.00	26.79	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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part III
Date/Time Prepared:
11/1/2021 6:08 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	56,538,654	10,415,861	66,954,515	1,870,399.00	35.80	1.00
2.00	Excluded area salaries (see instructions)	4,052,619	0	4,052,619	154,263.00	26.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)	52,486,035	10,415,861	62,901,896	1,716,136.00	36.65	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,719,942	0	9,719,942	212,482.00	45.74	4.00
5.00	Subtotal wage-related costs (see inst.)	17,268,627	0	17,268,627	0.00	27.45	5.00
6.00	Total (sum of lines 3 thru 5)	79,474,604	10,415,861	89,890,465	1,928,618.00	46.61	6.00
7.00	Total overhead cost (see instructions)	19,782,472	9,421,097	29,203,569	667,885.00	43.73	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/1/2021 6:08 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,298,998	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,539,369	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	309,225	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	84,875	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	811,114	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	6,018,506	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	364,287	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	106,904	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,533,278	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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet S-3
Part V
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet S-10 Date/Time Prepared: 11/1/2021 6:08 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.460972	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		108,996,708	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		208,592,062	6.00
7.00	Medicaid cost (line 1 times line 6)		96,155,100	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)	6,884,986	68,058	6,953,044
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,173,786	68,058	3,241,844
22.00	Payments received from patients for amounts previously written off as charity care	237,534	0	237,534
23.00	Cost of charity care (line 21 minus line 22)	2,936,252	68,058	3,004,310
				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)		9,846,608	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		487,627	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		750,196	27.01
28.00	Non-Medicare bad debt expense (see instructions)		9,096,412	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,455,760	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,460,070	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,460,070	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,827,000	2,827,000	7,063,343	9,890,343	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,138,900	4,138,900	0	4,138,900	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	941,206	20,403,837	21,345,043	10,142,193	31,487,236	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,616,774	53,805,118	62,421,892	-17,205,536	45,216,356	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,089,609	11,542,284	13,631,893	0	13,631,893	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	708,002	708,002	0	708,002	8.00
9.00	00900	HOUSEKEEPING	1,487,546	861,135	2,348,681	0	2,348,681	9.00
10.00	01000	DIETARY	0	2,716,889	2,716,889	-1,404,064	1,312,825	10.00
11.00	01100	CAFETERIA	0	0	0	1,404,064	1,404,064	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,927,089	140,015	2,067,104	0	2,067,104	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	523,129	-35,960	487,169	0	487,169	14.00
15.00	01500	PHARMACY	0	13,759,111	13,759,111	0	13,759,111	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,056,269	375,660	1,431,929	0	1,431,929	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,500,537	3,092,704	4,593,241	-2,231,283	2,361,958	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	162,135	12,036	174,171	2,231,283	2,405,454	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,113,678	2,627,252	14,740,930	0	14,740,930	30.00
31.00	03100	INTENSIVE CARE UNIT	4,443,645	657,116	5,100,761	0	5,100,761	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	0	1,282,704	1,282,704	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	1,886,005	995,631	2,881,636	0	2,881,636	40.00
41.00	04100	SUBPROVIDER - IRF	567,083	895,089	1,462,172	0	1,462,172	41.00
43.00	04300	NURSERY	1,601,364	587,581	2,188,945	-1,282,704	906,241	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,274,007	3,853,305	6,127,312	-3,272,137	2,855,175	50.00
50.01	03340	GI LAB	437,836	294,689	732,525	0	732,525	50.01
51.00	05100	RECOVERY ROOM	427,076	17,323	444,399	0	444,399	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,849,874	767,966	2,617,840	0	2,617,840	52.00
53.00	05300	ANESTHESIOLOGY	2,255,340	798,417	3,053,757	0	3,053,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,888,030	840,519	3,728,549	-660,127	3,068,422	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	435,649	1,031,601	1,467,250	0	1,467,250	55.00
56.00	05600	RADIOISOTOPE	237,259	253,151	490,410	0	490,410	56.00
57.00	05700	CT SCAN	616,883	140,853	757,736	0	757,736	57.00
58.00	05800	MRI	173,647	6,760	180,407	0	180,407	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,558,450	6,360,887	7,919,337	-1,327,410	6,591,927	59.00
60.00	06000	LABORATORY	3,465,671	4,738,949	8,204,620	0	8,204,620	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,028,271	328,537	1,356,808	-109,433	1,247,375	65.00
66.00	06600	PHYSICAL THERAPY	828,471	11,777	840,248	0	840,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	444,361	4,781	449,142	0	449,142	67.00
68.00	06800	SPEECH PATHOLOGY	188,036	36,608	224,644	0	224,644	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,868	1,586	43,454	0	43,454	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,203,012	2,203,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,166,095	3,166,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	553,262	553,262	0	553,262	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	153,650	9,562	163,212	0	163,212	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	200,775	16,090	216,865	0	216,865	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	822,878	183,146	1,006,024	0	1,006,024	76.06
76.07	03958	SLEEP LAB	0	411,214	411,214	0	411,214	76.07
76.08	03640	UROLOGY	6,470	32,240	38,710	0	38,710	76.08
76.09	03959	ADDP OP	-2,641	420	-2,221	0	-2,221	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	92,083	39,593	131,676	0	131,676	76.11
76.12	03961	MENTAL HEALTH CENTER	496,174	5,534	501,708	0	501,708	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
76.97	07697	CARDIAC REHABILITATION	261,434	11,920	273,354	0	273,354	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	7,540,616	3,573,022	11,113,638	0	11,113,638	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	7,142,118	2,151,832	9,293,950	0	9,293,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,780,355	146,584,944	221,365,299	0	221,365,299	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	173,529	16,570	190,099	0	190,099	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,313,639	5,941,333	7,254,972	0	7,254,972	192.00
192.01	19201	DNBAR CLINIC	50,609	39,120	89,729	0	89,729	192.01
192.02	19202	PHILLIPS HEALTH	49,196	72,862	122,058	0	122,058	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	12,558	22,646	35,204	0	35,204	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	76,379,886	152,677,475	229,057,361	0	229,057,361	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-155,841	9,734,502	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,138,900	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,255,091	30,232,145	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,578,905	36,637,451	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-429,188	13,202,705	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	708,002	8.00
9.00	00900	HOUSEKEEPING	0	2,348,681	9.00
10.00	01000	DIETARY	0	1,312,825	10.00
11.00	01100	CAFETERIA	-118,565	1,285,499	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-3,177	2,063,927	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-495	486,674	14.00
15.00	01500	PHARMACY	0	13,759,111	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,431,929	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	-68,358	2,293,600	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-875,123	1,530,331	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,670,149	12,070,781	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,801,761	3,299,000	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	1,282,704	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	-520,358	2,361,278	40.00
41.00	04100	SUBPROVIDER - IRF	0	1,462,172	41.00
43.00	04300	NURSERY	-471,695	434,546	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-469,929	2,385,246	50.00
50.01	03340	GI LAB	0	732,525	50.01
51.00	05100	RECOVERY ROOM	0	444,399	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,617,840	52.00
53.00	05300	ANESTHESIOLOGY	-2,854,737	199,020	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-33,212	3,035,210	54.00
54.01	05401	MRI CENTER	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-776,308	690,942	55.00
56.00	05600	RADIOISOTOPE	0	490,410	56.00
57.00	05700	CT SCAN	0	757,736	57.00
58.00	05800	MRI	0	180,407	58.00
59.00	05900	CARDIAC CATHETERIZATION	-2,192,558	4,399,369	59.00
60.00	06000	LABORATORY	-36,386	8,168,234	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,247,375	65.00
66.00	06600	PHYSICAL THERAPY	0	840,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	449,142	67.00
68.00	06800	SPEECH PATHOLOGY	-3,046	221,598	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	43,454	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,203,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,166,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	553,262	74.00
76.00	03951	EMG	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	163,212	76.02
76.03	03954	MERCY ENT	0	0	76.03
76.04	03955	WOUND CARE CENTER	-119,094	97,771	76.04
76.05	03956	CARDIAC REHAB	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	-567,913	438,111	76.06
76.07	03958	SLEEP LAB	0	411,214	76.07
76.08	03640	UROLOGY	-32,240	6,470	76.08
76.09	03959	ADDP OP	0	-2,221	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	131,676	76.11
76.12	03961	MENTAL HEALTH CENTER	-241,888	259,820	76.12
76.13	03650	VEIN CLINIC	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	-33,867	239,487	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
76.99	07699	LITHOTRIPSY	6.00	7.00	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	MERCY CLINICS	-5,267,446	5,846,192	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	90.03
91.00	09100	EMERGENCY	-4,754,433	4,539,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-34,331,763	187,033,536	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	0	190,099	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,254,972	192.00
192.01	19201	DNBAR CLINIC	0	89,729	192.01
192.02	19202	PHILLIPS HEALTH	0	122,058	192.02
192.03	19204	OTHER HOME HEALTH	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	35,204	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-34,331,763	194,725,598	200.00

RECLASSIFICATIONS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet A-6
Date/Time Prepared:
11/1/2021 6:08 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	158,000	1.00	
	TOTALS		0	158,000		
	B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,203,012	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	
	TOTALS		0	2,203,012		
	C - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	0	1,404,064	1.00	
	TOTALS		0	1,404,064		
	D - SPECIAL CARE NURSERY					
1.00	NURSERY INTENSIVE CARE CENTER	32.01	1,203,129	79,575	1.00	
	TOTALS		1,203,129	79,575		
	E - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,166,095	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	3,166,095		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,845,597	1.00	
	TOTALS		0	4,845,597		
	G - LOSS ON RETIREMENT OF DEBT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	9,421,097	0	1.00	
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	721,096	2.00	
9.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,059,746	9.00	
	TOTALS		9,421,097	2,780,842		
	I - INTERNS RESIDENTS OTHER COSTS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	994,764	1,236,519	1.00	
	TOTALS		994,764	1,236,519		
500.00	Grand Total: Increases		11,618,990	15,873,704	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet A-6
Date/Time Prepared:
11/1/2021 6:08 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	158,000	9		1.00
	TOTALS		0	158,000			
	B - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	940,418	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	660,127	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	493,034	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	109,433	0		4.00
	TOTALS		0	2,203,012			
	C - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	1,404,064	0		1.00
	TOTALS		0	1,404,064			
	D - SPECIAL CARE NURSERY						
1.00	NURSERY	43.00	1,203,129	79,575	0		1.00
	TOTALS		1,203,129	79,575			
	E - IMPLANT SUPPLIES						
1.00	OPERATING ROOM	50.00	0	2,331,719	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	834,376	0		2.00
	TOTALS		0	3,166,095			
	F - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,845,597	9		1.00
	TOTALS		0	4,845,597			
	G - LOSS ON RETIREMENT OF DEBT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,421,097	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	721,096	0		2.00
9.00	ADMINISTRATIVE & GENERAL	5.00	0	2,059,746	9		9.00
	TOTALS		0	12,201,939			
	I - INTERNS RESIDENTS OTHER COSTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	994,764	1,236,519	0		1.00
	TOTALS		994,764	1,236,519			
500.00	Grand Total: Decreases		2,197,893	25,294,801			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet A-7
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	25,078,000	0	0	0	70,000	1.00	
2.00	Land Improvements	7,313	0	0	0	0	2.00	
3.00	Buildings and Fixtures	3,949,042	0	0	0	9,280	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	6,722,478	0	0	0	876,971	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	35,756,833	0	0	0	956,251	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	35,756,833	0	0	0	956,251	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	25,008,000	0					1.00
2.00	Land Improvements	7,313	0					
3.00	Buildings and Fixtures	3,939,762	0					
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	5,845,507	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	34,800,582	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	34,800,582	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet A-7
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,827,000	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,138,900	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,965,900	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	2,827,000				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,138,900				2.00
3.00	Total (sum of lines 1-2)	0	6,965,900				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet A-7
Part III
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	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	9,734,502	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,138,900	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,873,402	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	0	0	0	9,734,502	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,138,900	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	13,873,402	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-96,459	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)						
4.00	Investment income - other (chapter 2)						
5.00	Trade, quantity, and time discounts (chapter 8)						
6.00	Refunds and rebates of expenses (chapter 8)						
7.00	Rental of provider space by suppliers (chapter 8)	B	-45,098	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
8.00	Telephone services (pay stations excluded) (chapter 21)						
9.00	Television and radio service (chapter 21)						
10.00	Parking lot (chapter 21)						
11.00	Provider-based physician adjustment	A-8-2	-24,027,246				
12.00	Sale of scrap, waste, etc. (chapter 23)						
13.00	Related organization transactions (chapter 10)	A-8-1	-4,143,934				
14.00	Laundry and linen service						
15.00	Cafeteria-employees and guests	B	-118,565	CAFETERIA	11.00		
16.00	Rental of quarters to employee and others						
17.00	Sale of medical and surgical supplies to other than patients	B	-495	CENTRAL SERVICES & SUPPLY	14.00		
18.00	Sale of drugs to other than patients						
19.00	Sale of medical records and abstracts						
20.00	Nursing and allied health education (tuition, fees, books, etc.)						
21.00	Vending machines						
22.00	Income from imposition of interest, finance or penalty charges (chapter 21)						
23.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						
24.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
25.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
26.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
27.00	Depreciation - CAP REL COSTS-BLDG & FIXT						
28.00	Depreciation - CAP REL COSTS-MVBLE EQUIP						
29.00	Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
30.00	Physicians' assistant						
30.99	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
31.00	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
32.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
	CAH HIT Adjustment for Depreciation and Interest						

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
33.60	MARKETING NON ALLOW BEN	A	-1,243	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.60
33.61	MARKETING COSTS	A	-357,785	ADMINISTRATIVE & GENERAL		5.00	0	33.61
33.62	MISC REVENUE	B	-30	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.62
33.73	MISCELLANEOUS INCOME	B	73,631	ADMINISTRATIVE & GENERAL		5.00	0	33.73
33.78	MISCELLANEOUS INCOME	B	-24,431	LABORATORY		60.00	0	33.78
33.79	REFERRAL LAB REVENUE	B	-11,955	LABORATORY		60.00	0	33.79
33.82	MERCYWORKS ADMIN COSTS	A	-139,183	ADMINISTRATIVE & GENERAL		5.00	0	33.82
33.88	SEVERANCE PAY	A	9,421,797	ADMINISTRATIVE & GENERAL		5.00	0	33.88
33.92	OTHER REVENUE	B	-1,260	CARDIAC REHABILITATION		76.97	0	33.92
33.93	OTHER REVENUE	B	-53,900	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00	0	33.93
33.94	OTHER REVENUE	B	-68,358	I&R SERVICES-SALARY & FRINGES APPRV		21.00	1	33.94
33.95	PHYSICIAN PART B BENEFITS	A	-1,390,534	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.95
33.97	OTHER REVENUE	B	-14,691	OPERATION OF PLANT		7.00	0	33.97
33.98	MISC REVENUE	B	-11,235	CARDIAC REHABILITATION		76.97	0	33.98
33.99	LOBBYING COSTS	B	-50,000	ADMINISTRATIVE & GENERAL		5.00	0	33.99
34.00	OTHER REVENUE	B	-45,126	MERCY CLINICS		90.01	0	34.00
34.01	APP PART B	A	-121,759	ADMINISTRATIVE & GENERAL		5.00	0	34.01
34.02	APP PART B	A	-3,177	NURSING ADMINISTRATION		13.00	0	34.02
34.03	APP PART B	A	-41,697	ADULTS & PEDIATRICS		30.00	0	34.03
34.04	APP PART B	A	-98,124	INTENSIVE CARE UNIT		31.00	0	34.04
34.05	APP PAET B	A	-25,286	OPERATING ROOM		50.00	0	34.05
34.06	APP PART B	A	-173,313	CARDIAC CATHETERIZATION		59.00	0	34.06
34.07	APP PART B	A	-119,094	WOUND CARE CENTER		76.04	0	34.07
34.08	APP PART B	A	-54,836	MENTAL HEALTH CENTER		76.12	0	34.08
34.09	APP PAET B	A	-335,613	MERCY CLINICS		90.01	0	34.09
34.10	APP PAET B	A	-411,794	EMERGENCY		91.00	0	34.10
34.11	APP BENEFITS	A	-229,719	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.11
34.12	MERCY WOKS BENEFITS	A	-30,347	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.12
34.13	OTHER REVENUE	B	-5,321	MERCY CLINICS		90.01	0	34.13
34.14	SEVERANCE PAY BENEFITS	A	721,096	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	34.14
34.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.15
34.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.16
34.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.17
34.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.18
34.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.19
34.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.20
35.00	LEASE REVENUE	B	-32,861	MERCY CLINICS		90.01	0	35.00
38.00	PROPERTY TAXES	A	-110,000	MERCY CLINICS		90.01	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	40.00
41.00	IMPAIRMENT EXPENSES	A	-251,937	ADMINISTRATIVE & GENERAL		5.00	0	41.00
42.00	MEDICAID ASSESSMENT	A	-11,901,881	ADMINISTRATIVE & GENERAL		5.00	0	42.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-34,331,763					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: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8-1

Date/Time Prepared:
11/1/2021 6:08 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	PROPERTY INSURANCE	153,762	168,046 1.00
2.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS EXPENSES	1,676,199	1,831,911 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMPENSATION	728,218	896,820 3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE EXPENSE	6,738,211	8,298,290 3.01
3.02		5.00	ADMINISTRATIVE & GENERAL	GENERAL INSURANCE	445,456	366,509 3.02
3.03		5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE EXPENSES	17,292,088	18,898,457 3.03
3.04		7.00	OPERATION OF PLANT	ENGINEERING COSTS	2,749,602	3,164,099 3.04
4.00		59.00	CARDIAC CATHETERIZATION	CATH LAB COSTS	3,232,558	3,532,850 4.00
4.01		68.00	SPEECH PATHOLOGY	SPPECH PATHOLOGY COSTS	32,796	35,842 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				33,048,890	37,192,824 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	SISTERS OF MERCY	100.00		0.00	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: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8-1

Date/Time Prepared:
11/1/2021 6:08 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-14,284	9		1.00
2.00	-155,712	0		2.00
3.00	-168,602	0		3.00
3.01	-1,560,079	0		3.01
3.02	78,947	0		3.02
3.03	-1,606,369	0		3.03
3.04	-414,497	0		3.04
4.00	-300,292	0		4.00
4.01	-3,046	0		4.01
5.00	-4,143,934			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	RELIGIOUS ORDER		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: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8-2

Date/Time Prepared:
11/1/2021 6:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	2,292,587	2,115,344	177,243	177,200	1,506	1.00
2.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0	0	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	821,223	821,223	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,628,452	2,628,452	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	1,703,637	1,703,637	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	520,358	520,358	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	444,643	444,643	0	0	0	7.00
8.00	50.01	AGGREGATE-GI LAB	0	0	0	0	0	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	2,854,737	2,854,737	0	0	0	9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	33,212	33,212	0	0	0	10.00
11.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	776,308	776,308	0	0	0	11.00
12.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	1,718,953	1,718,953	0	0	0	12.00
13.00	90.01	AGGREGATE-MERCY CLINICS	4,738,525	4,738,525	0	0	0	13.00
14.00	43.00	AGGREGATE-NURSERY	471,695	471,695	0	0	0	14.00
15.00	76.08	AGGREGATE-UROLOGY	32,240	32,240	0	0	0	15.00
16.00	76.06	AGGREGATE-PRE-BIRTH CENTER	567,913	567,913	0	0	0	16.00
17.00	76.12	AGGREGATE-MENTAL HEALTH CENTER	187,052	187,052	0	0	0	17.00
18.00	76.97	AGGREGATE-CARDIAC REHABILITATION	67,120	0	67,120	177,200	537	18.00
19.00	91.00	AGGREGATE-EMERGENCY	4,342,639	4,342,639	0	0	0	19.00
20.00	0.00	AGGREGATE-	0	0	0	0	0	20.00
200.00			24,201,294	23,956,931	244,363		2,043	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8-2

Date/Time Prepared:
11/1/2021 6:08 pm

	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	AGGREGATE-ADMINISTRATIVE & GENERAL	128,300	6,415	0	0	0	1.00
2.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0	0	2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	0	0	3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	7.00
8.00	50.01	AGGREGATE-GI LAB	0	0	0	0	0	8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	10.00
11.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	0	0	11.00
12.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	0	12.00
13.00	90.01	AGGREGATE-MERCY CLINICS	0	0	0	0	0	13.00
14.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	14.00
15.00	76.08	AGGREGATE-UROLOGY	0	0	0	0	0	15.00
16.00	76.06	AGGREGATE-PRE-BIRTH CENTER	0	0	0	0	0	16.00
17.00	76.12	AGGREGATE-MENTAL HEALTH CENTER	0	0	0	0	0	17.00
18.00	76.97	AGGREGATE-CARDIAC REHABILITATION	45,748	2,287	0	0	0	18.00
19.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	19.00
20.00	0.00	AGGREGATE-	0	0	0	0	0	20.00
200.00			174,048	8,702	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet A-8-2

Date/Time Prepared:
11/1/2021 6:08 pm

	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	AGGREGATE-ADMINISTRATIVE & GENERAL	0	128,300	48,943	2,164,287		1.00
2.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0		2.00
3.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	0	0	821,223		3.00
4.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,628,452		4.00
5.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	1,703,637		5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	520,358		6.00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	444,643		7.00
8.00	50.01	AGGREGATE-GI LAB	0	0	0	0		8.00
9.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	2,854,737		9.00
10.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	33,212		10.00
11.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	776,308		11.00
12.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	1,718,953		12.00
13.00	90.01	AGGREGATE-MERCY CLINICS	0	0	0	4,738,525		13.00
14.00	43.00	AGGREGATE-NURSERY	0	0	0	471,695		14.00
15.00	76.08	AGGREGATE-UROLOGY	0	0	0	32,240		15.00
16.00	76.06	AGGREGATE-PRE-BIRTH CENTER	0	0	0	567,913		16.00
17.00	76.12	AGGREGATE-MENTAL HEALTH CENTER	0	0	0	187,052		17.00
18.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	45,748	21,372	21,372		18.00
19.00	91.00	AGGREGATE-EMERGENCY	0	0	0	4,342,639		19.00
20.00	0.00	AGGREGATE-	0	0	0	0		20.00
200.00			0	174,048	70,315	24,027,246		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet 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	9,734,502	9,734,502			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,138,900		4,138,900		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,232,145	89,533	0	30,321,678	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,637,451	658,580	3,664,479	2,942,165	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,202,705	3,496,128	13,447	735,534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	708,002	156,072	0	0	8.00
9.00	00900	HOUSEKEEPING	2,348,681	37,080	0	523,610	9.00
10.00	01000	DIETARY	1,312,825	173,259	0	0	10.00
11.00	01100	CAFETERIA	1,285,499	139,148	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,063,927	25,088	0	677,210	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	486,674	128,114	7,202	184,139	14.00
15.00	01500	PHARMACY	13,759,111	0	1,237	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,431,929	81,533	0	371,802	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,293,600	141,870	0	219,452	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,530,331	47,175	472	57,071	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,070,781	1,440,572	75,587	3,526,187	30.00
31.00	03100	INTENSIVE CARE UNIT	3,299,000	112,774	106,843	1,046,882	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	1,282,704	35,727	1,026	423,497	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	2,361,278	221,061	3,493	503,659	40.00
41.00	04100	SUBPROVIDER - IRF	1,462,172	87,867	28,952	199,611	41.00
43.00	04300	NURSERY	434,546	20,866	957	140,177	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,385,246	531,390	11,791	791,541	50.00
50.01	03340	GI LAB	732,525	28,899	311	154,117	50.01
51.00	05100	RECOVERY ROOM	444,399	35,628	9,522	150,329	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,617,840	265,266	13,190	651,148	52.00
53.00	05300	ANESTHESIOLOGY	199,020	6,004	8,725	50,504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,035,210	377,792	107,309	1,016,575	54.00
54.01	05401	MRI CENTER	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	690,942	9,798	1,398	153,347	55.00
56.00	05600	RADIOISOTOPE	490,410	35,744	3,018	83,514	56.00
57.00	05700	CT SCAN	757,736	8,247	2,066	217,140	57.00
58.00	05800	MRI	180,407	61,178	8,715	61,123	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,399,369	294,082	6,525	460,466	59.00
60.00	06000	LABORATORY	8,168,234	252,549	13,799	1,219,902	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,247,375	14,631	0	361,947	65.00
66.00	06600	PHYSICAL THERAPY	840,248	92,485	659	291,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,142	35,331	0	156,413	67.00
68.00	06800	SPEECH PATHOLOGY	221,598	27,348	0	66,188	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	43,454	34,705	1,481	14,737	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,203,012	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,166,095	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	553,262	14,647	3,264	0	74.00
76.00	03951	EMG	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	163,212	80,428	2,879	54,084	76.02
76.03	03954	MERCY ENT	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	97,771	11,249	19,766	28,751	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	438,111	0	0	89,747	76.06
76.07	03958	SLEEP LAB	411,214	0	0	0	76.07
76.08	03640	UROLOGY	6,470	14,697	8,271	2,277	76.08
76.09	03959	ADDP OP	-2,221	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	24,000	0	0	76.10
76.11	03960	DIABETES TREATMENT	131,676	0	0	32,413	76.11

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
76.12	03961	MENTAL HEALTH CENTER	259,820	0	0	57,828	317,648	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	239,487	0	0	68,398	307,885	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	5,846,192	74,671	2,219	919,387	6,842,469	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	4,539,517	244,598	610	11,225,681	16,010,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	187,033,536	9,667,814	4,129,213	29,930,171	186,565,654	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	190,099	0	0	61,082	251,181	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,254,972	66,688	0	308,461	7,630,121	192.00
192.01	19201	DNBAR CLINIC	89,729	0	2,496	227	92,452	192.01
192.02	19202	PHILLIPS HEALTH	122,058	0	5,974	17,317	145,349	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	35,204	0	1,217	4,420	40,841	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	194,725,598	9,734,502	4,138,900	30,321,678	194,725,598	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,902,675					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,098,952	0	22,546,766			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	252,516	0	640,938	1,757,528		8.00
9.00	00900	HOUSEKEEPING	850,232	0	152,275	0	3,911,878	9.00
10.00	01000	DIETARY	434,292	0	711,521	0	127,951	10.00
11.00	01100	CAFETERIA	416,337	0	571,439	0	102,760	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	808,399	0	103,030	0	18,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	235,582	0	526,122	0	94,611	14.00
15.00	01500	PHARMACY	4,021,310	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	550,948	0	334,829	0	60,211	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	775,872	0	582,616	0	104,770	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	477,825	0	193,731	0	34,838	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,001,123	0	5,915,977	1,166,009	1,063,851	30.00
31.00	03100	INTENSIVE CARE UNIT	1,334,217	0	463,125	233,526	83,283	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	509,359	0	146,721	0	26,384	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	902,870	0	907,826	242,250	163,252	40.00
41.00	04100	SUBPROVIDER - IRF	519,777	0	360,841	115,743	64,889	41.00
43.00	04300	NURSERY	0	0	85,689	0	15,409	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,087,120	0	2,182,251	0	392,428	50.00
50.01	03340	GI LAB	267,648	0	118,677	0	21,341	50.01
51.00	05100	RECOVERY ROOM	186,997	0	146,314	0	26,311	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,036,701	0	1,089,364	0	195,897	52.00
53.00	05300	ANESTHESIOLOGY	77,225	0	24,657	0	4,434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,325,855	0	1,551,474	0	278,997	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	250,006	0	40,236	0	7,236	55.00
56.00	05600	RADIOISOTOPE	179,051	0	146,788	0	26,397	56.00
57.00	05700	CT SCAN	287,911	0	33,869	0	6,091	57.00
58.00	05800	MRI	91,010	0	251,241	0	45,180	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,508,082	0	1,207,703	0	217,178	59.00
60.00	06000	LABORATORY	2,821,417	0	1,037,138	0	186,506	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	474,582	0	60,084	0	10,805	65.00
66.00	06600	PHYSICAL THERAPY	357,996	0	379,808	0	68,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,292	0	145,095	0	26,092	67.00
68.00	06800	SPEECH PATHOLOGY	92,094	0	112,310	0	20,196	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,581	0	142,521	0	25,629	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	643,806	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	925,256	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	166,919	0	60,151	0	10,817	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	87,848	0	330,291	0	59,395	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	46,038	0	46,197	0	8,308	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	154,261	0	0	0	0	76.06
76.07	03958	SLEEP LAB	120,173	0	0	0	0	76.07
76.08	03640	UROLOGY	9,268	0	60,355	0	10,853	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	7,014	0	98,559	0	17,724	76.10
76.11	03960	DIABETES TREATMENT	47,953	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	92,829	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	89,976	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 MERCY CLINICS	1,999,636	0	306,650	0	55,144	90.01
90.02	09002 MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	4,678,865	0	1,004,488	0	180,634	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41,518,021	0	22,272,901	1,757,528	3,862,630	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100 RESEARCH	73,405	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,229,819	0	273,865	0	49,248	192.00
192.01	19201 DNBAR CLINIC	27,018	0	0	0	0	192.01
192.02	19202 PHILLIPS HEALTH	42,477	0	0	0	0	192.02
192.03	19204 OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205 VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203 DOCTORS OFFICE	11,935	0	0	0	0	192.05
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	43,902,675	0	22,546,766	1,757,528	3,911,878	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,759,848					10.00
11.00	01100	CAFETERIA	0	2,515,183				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	70,226	0	3,766,408		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,355	0	0	1,710,799	14.00
15.00	01500	PHARMACY	0	0	0	0	11,072	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,488	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	32,329	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	28,443	0	0	56	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,830,986	631,796	0	1,658,855	157,890	30.00
31.00	03100	INTENSIVE CARE UNIT	366,705	165,096	0	309,199	81,581	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	45,297	0	77,580	7,641	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	380,406	91,453	0	201,189	2,965	40.00
41.00	04100	SUBPROVIDER - IRF	181,751	33,696	0	103,035	7,546	41.00
43.00	04300	NURSERY	0	22,511	0	46,155	5,197	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	114,387	0	268,000	92,467	50.00
50.01	03340	GI LAB	0	23,558	0	47,154	54,185	50.01
51.00	05100	RECOVERY ROOM	0	17,173	0	37,217	1,772	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	96,587	0	188,802	58,839	52.00
53.00	05300	ANESTHESIOLOGY	0	46,785	0	87,924	14,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,505	0	0	23,884	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	19,504	0	0	735	55.00
56.00	05600	RADIOISOTOPE	0	10,036	0	0	12,390	56.00
57.00	05700	CT SCAN	0	29,746	0	0	14,364	57.00
58.00	05800	MRI	0	6,963	0	0	1,254	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	65,862	0	155,552	16,337	59.00
60.00	06000	LABORATORY	0	206,010	0	0	537,310	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	57,264	0	120,021	4,554	65.00
66.00	06600	PHYSICAL THERAPY	0	38,355	0	0	115	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,216	0	0	361	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,772	0	0	58	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,996	0	0	284	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	186,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	284,943	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	1,968	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	9,511	0	0	1,128	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	7,530	0	18,254	2,541	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	16,047	0	0	1,049	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	531	0	0	0	76.08
76.09	03959	ADDP OP	0	8	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	4,256	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	15,210	0	0	2	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	9,863	0	0	510	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	43,448	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	219,664	0	447,471	75,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,759,848	2,438,029	0	3,766,408	1,706,160	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	9,056	0	0	17	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	62,060	0	0	3,212	192.00
192.01	19201	DNBAR CLINIC	0	1,111	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	3,782	0	0	109	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	1,145	0	0	1,301	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,759,848	2,515,183	0	3,766,408	1,710,799	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	17,792,730					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,905,742				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	370,744	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	89,221	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	42,720	0	0	0	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	52,103	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	25,133	0	0	0	41.00
43.00	04300	NURSERY	0	21,219	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	102,539	0	0	0	50.00
50.01	03340	GI LAB	0	28,642	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	10,958	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	54,013	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	21,816	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	222,145	0	0	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	30,392	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	36,783	0	0	0	56.00
57.00	05700	CT SCAN	0	214,319	0	0	0	57.00
58.00	05800	MRI	0	45,618	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	132,978	0	0	0	59.00
60.00	06000	LABORATORY	0	568,087	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	55,774	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,394	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,158	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,627	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,200	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,820	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,319	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,792,730	329,590	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,837	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	4,084	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	3,745	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	16,444	0	0	0	76.06
76.07	03958	SLEEP LAB	0	11,314	0	0	0	76.07
76.08	03640	UROLOGY	0	1,511	0	0	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	2,073	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	542	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	2,086	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	2,528	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	8,438	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	299,828	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,792,730	2,905,742	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,792,730	2,905,742	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	4,150,509					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		2,369,942				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,437,330	1,391,716	0	38,739,404	-3,829,046	30.00
31.00	03100	INTENSIVE CARE UNIT	163,416	93,311	0	7,948,179	-256,727	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	120,318	68,701	0	2,787,675	-189,019	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	0	6,033,805	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	3,191,013	0	41.00
43.00	04300	NURSERY	0	0	0	792,726	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	359,157	205,079	0	8,523,396	-564,236	50.00
50.01	03340	GI LAB	0	0	0	1,477,057	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	1,066,620	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,267,647	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	542,027	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	549,959	314,027	0	8,948,732	-863,986	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,203,594	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,024,131	0	56.00
57.00	05700	CT SCAN	0	0	0	1,571,489	0	57.00
58.00	05800	MRI	0	0	0	752,689	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,464,134	0	59.00
60.00	06000	LABORATORY	0	0	0	15,010,952	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,407,037	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,087,978	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,032,100	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	558,191	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	294,588	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,059,618	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,403,613	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,122,320	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	816,865	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	792,860	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	290,150	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	715,659	0	76.06
76.07	03958	SLEEP LAB	0	0	0	542,701	0	76.07
76.08	03640	UROLOGY	0	0	0	114,233	0	76.08
76.09	03959	ADDP OP	0	0	0	-2,213	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	149,370	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	216,840	0	76.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00		23.00	24.00	25.00
76.12	03961	MENTAL HEALTH CENTER	0	0	0	427,775	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	410,762	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	9,255,785	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	520,329	297,108	0	23,734,592	-817,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,150,509	2,369,942	0	183,776,094	-6,520,451	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	333,659	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	10,248,325	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	120,581	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	191,717	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	55,222	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,150,509	2,369,942	0	194,725,598	-6,520,451	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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From 07/01/2020
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	34.02
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
50.01	03340	GI LAB	50.01
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	MRI CENTER	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03951	EMG	76.00
76.01	03952	CARDIOVASCULAR LAB	76.01
76.02	03953	MERCY EYE CENTER	76.02
76.03	03954	MERCY ENT	76.03
76.04	03955	WOUND CARE CENTER	76.04
76.05	03956	CARDIAC REHAB	76.05
76.06	03957	PRE-BIRTH CENTER	76.06
76.07	03958	SLEEP LAB	76.07
76.08	03640	UROLOGY	76.08
76.09	03959	ADDP OP	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	76.10
76.11	03960	DIABETES TREATMENT	76.11
76.12	03961	MENTAL HEALTH CENTER	76.12
76.13	03650	VEIN CLINIC	76.13
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0158

Period:
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Cost Center Description		Total	
		26.00	
OUTPATIENT SERVICE COST CENTERS			
90.01	09001 MERCY CLINICS	9,255,785	90.01
90.02	09002 MERCY CLINIC STATE ST	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0	90.03
91.00	09100 EMERGENCY	22,917,155	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	93.99
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	177,255,643	118.00
NONREIMBURSABLE COST CENTERS			
191.00	19100 RESEARCH	333,659	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	10,248,325	192.00
192.01	19201 DNBAR CLINIC	120,581	192.01
192.02	19202 PHILLIPS HEALTH	191,717	192.02
192.03	19204 OTHER HOME HEALTH	0	192.03
192.04	19205 VITAS HOSPICE	0	192.04
192.05	19203 DOCTORS OFFICE	55,222	192.05
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951 SENIOR FRIENDS	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	188,205,147	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
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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	89,533	0	89,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,105	658,580	3,664,479	4,420,164	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	86,780	3,496,128	13,447	3,596,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,072	0	156,072	8.00
9.00	00900	HOUSEKEEPING	8,175	37,080	0	45,255	9.00
10.00	01000	DIETARY	2,122	173,259	0	175,381	10.00
11.00	01100	CAFETERIA	1,771	139,148	0	140,919	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	25,088	0	25,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	481,336	128,114	7,202	616,652	14.00
15.00	01500	PHARMACY	0	0	1,237	1,237	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	81,533	0	81,533	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	141,870	0	141,870	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	47,175	472	47,647	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,843	1,440,572	75,587	1,542,002	30.00
31.00	03100	INTENSIVE CARE UNIT	5,299	112,774	106,843	224,916	31.00
32.00	03200	CORONARY CARE UNIT	686	0	0	686	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	35,727	1,026	36,753	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	59	221,061	3,493	224,613	40.00
41.00	04100	SUBPROVIDER - IRF	2,716	87,867	28,952	119,535	41.00
43.00	04300	NURSERY	0	20,866	957	21,823	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,086,762	531,390	11,791	1,629,943	50.00
50.01	03340	GI LAB	149,230	28,899	311	178,440	50.01
51.00	05100	RECOVERY ROOM	5,670	35,628	9,522	50,820	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,345	265,266	13,190	287,801	52.00
53.00	05300	ANESTHESIOLOGY	0	6,004	8,725	14,729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	377,792	107,309	485,101	54.00
54.01	05401	MRI CENTER	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,798	1,398	11,196	55.00
56.00	05600	RADIOISOTOPE	0	35,744	3,018	38,762	56.00
57.00	05700	CT SCAN	0	8,247	2,066	10,313	57.00
58.00	05800	MRI	924,190	61,178	8,715	994,083	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	294,082	6,525	300,607	59.00
60.00	06000	LABORATORY	0	252,549	13,799	266,348	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	44,839	14,631	0	59,470	65.00
66.00	06600	PHYSICAL THERAPY	0	92,485	659	93,144	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	35,331	0	35,331	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,348	0	27,348	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	34,705	1,481	36,186	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	14,647	3,264	17,911	74.00
76.00	03951	EMG	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	80,428	2,879	83,307	76.02
76.03	03954	MERCY ENT	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	484	11,249	19,766	31,499	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	76.07
76.08	03640	UROLOGY	0	14,697	8,271	22,968	76.08
76.09	03959	ADDP OP	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	24,000	0	24,000	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	76.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
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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
76.13	03650	VEIN CLINIC	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	202	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	420,557	74,671	2,219	497,447	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	244,598	610	245,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,352,969	9,667,814	4,129,213	17,149,996	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	180	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	66,688	0	66,688	192.00
192.01	19201	DNBAR CLINIC	0	0	2,496	2,496	192.01
192.02	19202	PHILLIPS HEALTH	0	0	5,974	5,974	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	1,217	1,217	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,352,969	9,734,502	4,138,900	17,226,371	89,533 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,428,849					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	514,338	0	4,112,864			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,474	0	116,917	298,463		8.00
9.00	00900	HOUSEKEEPING	85,771	0	27,777	0	160,349	9.00
10.00	01000	DIETARY	43,811	0	129,792	0	5,245	10.00
11.00	01100	CAFETERIA	42,000	0	104,239	0	4,212	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	81,551	0	18,794	0	759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,765	0	95,972	0	3,878	14.00
15.00	01500	PHARMACY	405,669	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,579	0	61,078	0	2,468	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	78,270	0	106,278	0	4,295	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	48,203	0	35,339	0	1,428	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	504,512	0	1,079,160	198,012	43,603	30.00
31.00	03100	INTENSIVE CARE UNIT	134,595	0	84,481	39,657	3,414	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	51,384	0	26,764	0	1,082	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	91,081	0	165,601	41,139	6,692	40.00
41.00	04100	SUBPROVIDER - IRF	52,435	0	65,823	19,655	2,660	41.00
43.00	04300	NURSERY	0	0	15,631	0	632	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	109,668	0	398,075	0	16,086	50.00
50.01	03340	GI LAB	27,000	0	21,648	0	875	50.01
51.00	05100	RECOVERY ROOM	18,864	0	26,690	0	1,079	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,582	0	198,716	0	8,030	52.00
53.00	05300	ANESTHESIOLOGY	7,790	0	4,498	0	182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,752	0	283,012	0	11,436	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	25,221	0	7,340	0	297	55.00
56.00	05600	RADIOISOTOPE	18,063	0	26,776	0	1,082	56.00
57.00	05700	CT SCAN	29,044	0	6,178	0	250	57.00
58.00	05800	MRI	9,181	0	45,830	0	1,852	58.00
59.00	05900	CARDIAC CATHETERIZATION	152,135	0	220,303	0	8,902	59.00
60.00	06000	LABORATORY	284,624	0	189,189	0	7,645	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	47,876	0	10,960	0	443	65.00
66.00	06600	PHYSICAL THERAPY	36,115	0	69,283	0	2,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,894	0	26,467	0	1,070	67.00
68.00	06800	SPEECH PATHOLOGY	9,290	0	20,487	0	828	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,782	0	25,998	0	1,051	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,947	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,340	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	16,839	0	10,973	0	443	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	8,862	0	60,250	0	2,435	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	4,644	0	8,427	0	341	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	15,562	0	0	0	0	76.06
76.07	03958	SLEEP LAB	12,123	0	0	0	0	76.07
76.08	03640	UROLOGY	935	0	11,010	0	445	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	708	0	17,979	0	726	76.10
76.11	03960	DIABETES TREATMENT	4,838	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	9,365	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	9,077	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 MERCY CLINICS	201,723	0	55,938	0	2,260	90.01
90.02	09002 MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	472,003	0	183,234	0	7,404	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4,188,285	0	4,062,907	298,463	158,330	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100 RESEARCH	7,405	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	224,944	0	49,957	0	2,019	192.00
192.01	19201 DNBAR CLINIC	2,726	0	0	0	0	192.01
192.02	19202 PHILLIPS HEALTH	4,285	0	0	0	0	192.02
192.03	19204 OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205 VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203 DOCTORS OFFICE	1,204	0	0	0	0	192.05
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,428,849	0	4,112,864	298,463	160,349	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	354,229					10.00
11.00	01100	CAFETERIA	0	291,370				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	8,135	0	136,326		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,602	0	0	746,413	14.00
15.00	01500	PHARMACY	0	0	0	0	4,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,629	0	0	1	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	3,745	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,295	0	0	24	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	235,009	73,190	0	60,043	68,886	30.00
31.00	03100	INTENSIVE CARE UNIT	47,067	19,125	0	11,192	35,593	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	5,247	0	2,808	3,334	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	48,825	10,594	0	7,282	1,294	40.00
41.00	04100	SUBPROVIDER - IRF	23,328	3,904	0	3,729	3,292	41.00
43.00	04300	NURSERY	0	2,608	0	1,671	2,267	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,251	0	9,700	40,343	50.00
50.01	03340	GI LAB	0	2,729	0	1,707	23,641	50.01
51.00	05100	RECOVERY ROOM	0	1,989	0	1,347	773	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,189	0	6,834	25,671	52.00
53.00	05300	ANESTHESIOLOGY	0	5,420	0	3,182	6,515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,856	0	0	10,421	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,259	0	0	321	55.00
56.00	05600	RADIOISOTOPE	0	1,163	0	0	5,406	56.00
57.00	05700	CT SCAN	0	3,446	0	0	6,267	57.00
58.00	05800	MRI	0	807	0	0	547	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,630	0	5,630	7,128	59.00
60.00	06000	LABORATORY	0	23,865	0	0	234,427	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,634	0	4,344	1,987	65.00
66.00	06600	PHYSICAL THERAPY	0	4,443	0	0	50	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,458	0	0	158	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,132	0	0	25	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	347	0	0	124	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	81,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	124,318	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	859	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	1,102	0	0	492	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	872	0	661	1,109	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	1,859	0	0	458	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	61	0	0	0	76.08
76.09	03959	ADDP OP	0	1	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	493	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	1,762	0	0	1	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	1,143	0	0	222	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	18,956	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	25,447	0	16,196	33,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	354,229	282,432	0	136,326	744,388	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	1,049	0	0	8	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,189	0	0	1,401	192.00
192.01	19201	DNBAR CLINIC	0	129	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	438	0	0	48	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	133	0	0	568	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	354,229	291,370	0	136,326	746,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	411,736					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	210,385				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	26,836	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,458	0			31.00
32.00	03200	CORONARY CARE UNIT	0	0	0			32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	3,092	0			32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0			34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0			34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0			34.02
40.00	04000	SUBPROVIDER - IPF	0	3,771	0			40.00
41.00	04100	SUBPROVIDER - IRF	0	1,819	0			41.00
43.00	04300	NURSERY	0	1,536	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,422	0			50.00
50.01	03340	GI LAB	0	2,073	0			50.01
51.00	05100	RECOVERY ROOM	0	793	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,910	0			52.00
53.00	05300	ANESTHESIOLOGY	0	1,579	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,080	0			54.00
54.01	05401	MRI CENTER	0	0	0			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,200	0			55.00
56.00	05600	RADIOISOTOPE	0	2,662	0			56.00
57.00	05700	CT SCAN	0	15,513	0			57.00
58.00	05800	MRI	0	3,302	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,625	0			59.00
60.00	06000	LABORATORY	0	41,179	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	4,037	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,331	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	808	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	624	0			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	87	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,869	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,977	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	411,736	23,857	0			73.00
74.00	07400	RENAL DIALYSIS	0	423	0			74.00
76.00	03951	EMG	0	0	0			76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0			76.01
76.02	03953	MERCY EYE CENTER	0	296	0			76.02
76.03	03954	MERCY ENT	0	0	0			76.03
76.04	03955	WOUND CARE CENTER	0	271	0			76.04
76.05	03956	CARDIAC REHAB	0	0	0			76.05
76.06	03957	PRE-BIRTH CENTER	0	1,190	0			76.06
76.07	03958	SLEEP LAB	0	819	0			76.07
76.08	03640	UROLOGY	0	109	0			76.08
76.09	03959	ADDP OP	0	0	0			76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	150	0			76.10
76.11	03960	DIABETES TREATMENT	0	39	0			76.11
76.12	03961	MENTAL HEALTH CENTER	0	151	0			76.12
76.13	03650	VEIN CLINIC	0	0	0			76.13
76.97	07697	CARDIAC REHABILITATION	0	183	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	611	0			90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0			90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0			90.03
91.00	09100	EMERGENCY	0	21,703	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	411,736	210,385	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	DNBAR CLINIC	0	0	0			192.01
192.02	19202	PHILLIPS HEALTH	0	0	0			192.02
192.03	19204	OTHER HOME HEALTH	0	0	0			192.03
192.04	19205	VITAS HOSPICE	0	0	0			192.04
192.05	19203	DOCTORS OFFICE	0	0	0			192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.00
194.01	07951	SENIOR FRIENDS	0	0	0			194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	411,736	210,385	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	335,106					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		136,104				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				3,841,661	0	30.00
31.00	03100	INTENSIVE CARE UNIT				609,588	0	31.00
32.00	03200	CORONARY CARE UNIT				686	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER				131,714	0	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT				0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT				0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT				0	0	34.02
40.00	04000	SUBPROVIDER - IPF				602,379	0	40.00
41.00	04100	SUBPROVIDER - IRF				296,769	0	41.00
43.00	04300	NURSERY				46,582	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				2,226,824	0	50.00
50.01	03340	GI LAB				258,568	0	50.01
51.00	05100	RECOVERY ROOM				102,799	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				648,655	0	52.00
53.00	05300	ANESTHESIOLOGY				44,044	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				959,659	0	54.00
54.01	05401	MRI CENTER				0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC				49,287	0	55.00
56.00	05600	RADIOISOTOPE				94,161	0	56.00
57.00	05700	CT SCAN				71,652	0	57.00
58.00	05800	MRI				1,055,782	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				713,319	0	59.00
60.00	06000	LABORATORY				1,050,878	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				136,819	0	65.00
66.00	06600	PHYSICAL THERAPY				208,027	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				85,648	0	67.00
68.00	06800	SPEECH PATHOLOGY				59,929	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY				66,619	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				148,394	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				219,635	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				435,593	0	73.00
74.00	07400	RENAL DIALYSIS				47,448	0	74.00
76.00	03951	EMG				0	0	76.00
76.01	03952	CARDIOVASCULAR LAB				0	0	76.01
76.02	03953	MERCY EYE CENTER				156,904	0	76.02
76.03	03954	MERCY ENT				0	0	76.03
76.04	03955	WOUND CARE CENTER				47,909	0	76.04
76.05	03956	CARDIAC REHAB				0	0	76.05
76.06	03957	PRE-BIRTH CENTER				19,334	0	76.06
76.07	03958	SLEEP LAB				12,942	0	76.07
76.08	03640	UROLOGY				35,535	0	76.08
76.09	03959	ADDP OP				1	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL				43,563	0	76.10
76.11	03960	DIABETES TREATMENT				5,466	0	76.11

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
76.12	03961	MENTAL HEALTH CENTER				11,450	0	76.12
76.13	03650	VEIN CLINIC				0	0	76.13
76.97	07697	CARDIAC REHABILITATION				10,827	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS				779,649	0	90.01
90.02	09002	MERCY CLINIC STATE ST				0	0	90.02
90.03	09003	MERCY CLINIC POLK ST				0	0	90.03
91.00	09100	EMERGENCY				1,037,429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	16,374,128	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH				8,642	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				353,108	0	192.00
192.01	19201	DNBAR CLINIC				5,352	0	192.01
192.02	19202	PHILLIPS HEALTH				10,796	0	192.02
192.03	19204	OTHER HOME HEALTH				0	0	192.03
192.04	19205	VITAS HOSPICE				0	0	192.04
192.05	19203	DOCTORS OFFICE				3,135	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.00
194.01	07951	SENIOR FRIENDS				0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.03
200.00		Cross Foot Adjustments	335,106	136,104	0	471,210	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	335,106	136,104	0	17,226,371	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
32.00	03200	CORONARY CARE UNIT	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	34.02
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
50.01	03340	GI LAB	50.01
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	MRI CENTER	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03951	EMG	76.00
76.01	03952	CARDIOVASCULAR LAB	76.01
76.02	03953	MERCY EYE CENTER	76.02
76.03	03954	MERCY ENT	76.03
76.04	03955	WOUND CARE CENTER	76.04
76.05	03956	CARDIAC REHAB	76.05
76.06	03957	PRE-BIRTH CENTER	76.06
76.07	03958	SLEEP LAB	76.07
76.08	03640	UROLOGY	76.08
76.09	03959	ADDP OP	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	76.10
76.11	03960	DIABETES TREATMENT	76.11
76.12	03961	MENTAL HEALTH CENTER	76.12
76.13	03650	VEIN CLINIC	76.13
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Total	
		26.00	
OUTPATIENT SERVICE COST CENTERS			
90.01	09001	MERCY CLINICS	779,649
90.02	09002	MERCY CLINIC STATE ST	0
90.03	09003	MERCY CLINIC POLK ST	0
91.00	09100	EMERGENCY	1,037,429
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,374,128
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	8,642
192.00	19200	PHYSICIANS' PRIVATE OFFICES	353,108
192.01	19201	DNBAR CLINIC	5,352
192.02	19202	PHILLIPS HEALTH	10,796
192.03	19204	OTHER HOME HEALTH	0
192.04	19205	VITAS HOSPICE	0
192.05	19203	DOCTORS OFFICE	3,135
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0
194.01	07951	SENIOR FRIENDS	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0
200.00		Cross Foot Adjustments	471,210
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	17,226,371

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	590,163					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,032,793				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,428	0	86,142,030			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,927	3,570,536	8,358,518	-43,902,675	150,228,598	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	211,956	13,102	2,089,609	0	17,447,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,462	0	0	0	864,074	8.00
9.00	00900	HOUSEKEEPING	2,248	0	1,487,546	0	2,909,371	9.00
10.00	01000	DIETARY	10,504	0	0	0	1,486,084	10.00
11.00	01100	CAFETERIA	8,436	0	0	0	1,424,647	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,521	0	1,923,913	0	2,766,225	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,767	7,017	523,129	0	806,129	14.00
15.00	01500	PHARMACY	0	1,205	0	0	13,760,348	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,943	0	1,056,269	0	1,885,264	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	8,601	0	623,449	0	2,654,922	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,860	460	162,135	0	1,635,049	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87,336	73,649	10,017,691	0	17,113,127	30.00
31.00	03100	INTENSIVE CARE UNIT	6,837	104,104	2,974,131	0	4,565,499	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	2,166	1,000	1,203,129	0	1,742,954	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	13,402	3,403	1,430,867	0	3,089,491	40.00
41.00	04100	SUBPROVIDER - IRF	5,327	28,210	567,083	0	1,778,602	41.00
43.00	04300	NURSERY	1,265	932	398,235	-596,546	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,216	11,489	2,248,721	0	3,719,968	50.00
50.01	03340	GI LAB	1,752	303	437,836	0	915,852	50.01
51.00	05100	RECOVERY ROOM	2,160	9,278	427,076	0	639,878	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,082	12,852	1,849,874	0	3,547,444	52.00
53.00	05300	ANESTHESIOLOGY	364	8,501	143,478	0	264,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,904	104,558	2,888,030	0	4,536,886	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	594	1,362	435,649	0	855,485	55.00
56.00	05600	RADIOISOTOPE	2,167	2,941	237,259	0	612,686	56.00
57.00	05700	CT SCAN	500	2,013	616,883	0	985,189	57.00
58.00	05800	MRI	3,709	8,492	173,647	0	311,423	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,829	6,358	1,308,157	0	5,160,442	59.00
60.00	06000	LABORATORY	15,311	13,445	3,465,671	0	9,654,484	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	887	0	1,028,271	0	1,623,953	65.00
66.00	06600	PHYSICAL THERAPY	5,607	642	828,471	0	1,225,010	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,142	0	444,361	0	640,886	67.00
68.00	06800	SPEECH PATHOLOGY	1,658	0	188,036	0	315,134	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,104	1,443	41,868	0	94,377	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,203,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,166,095	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	888	3,180	0	0	571,173	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	4,876	2,805	153,650	0	300,603	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	682	19,259	81,681	0	157,537	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	254,965	0	527,858	76.06
76.07	03958	SLEEP LAB	0	0	0	0	411,214	76.07
76.08	03640	UROLOGY	891	8,059	6,470	0	31,715	76.08
76.09	03959	ADDP OP	0	0	0	2,221	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	1,455	0	0	0	24,000	76.10
76.11	03960	DIABETES TREATMENT	0	0	92,083	0	164,089	76.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
76.12	03961	MENTAL HEALTH CENTER	0	0	164,286	0	317,648	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	194,314	0	307,885	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	4,527	2,162	2,611,925	0	6,842,469	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	14,829	594	31,891,414	0	16,010,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	586,120	4,023,354	85,029,780	-44,497,000	142,068,654	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	173,529	0	251,181	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,043	0	876,321	0	7,630,121	192.00
192.01	19201	DNBAR CLINIC	0	2,432	646	0	92,452	192.01
192.02	19202	PHILLIPS HEALTH	0	5,821	49,196	0	145,349	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	1,186	12,558	0	40,841	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	9,734,502	4,138,900	30,321,678		43,902,675	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.494599	1.026311	0.351996		0.292239	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			89,533		4,428,849	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001039		0.029481	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: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	332,852				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,462	24,979			8.00
9.00	00900	HOUSEKEEPING	0	2,248	0	321,142		9.00
10.00	01000	DIETARY	0	10,504	0	10,504	24,979	10.00
11.00	01100	CAFETERIA	0	8,436	0	8,436	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,521	0	1,521	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,767	0	7,767	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,943	0	4,943	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	8,601	0	8,601	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,860	0	2,860	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	87,336	16,572	87,336	16,572	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,837	3,319	6,837	3,319	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	2,166	0	2,166	0	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	13,402	3,443	13,402	3,443	40.00
41.00	04100	SUBPROVIDER - IRF	0	5,327	1,645	5,327	1,645	41.00
43.00	04300	NURSERY	0	1,265	0	1,265	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	32,216	0	32,216	0	50.00
50.01	03340	GI LAB	0	1,752	0	1,752	0	50.01
51.00	05100	RECOVERY ROOM	0	2,160	0	2,160	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,082	0	16,082	0	52.00
53.00	05300	ANESTHESIOLOGY	0	364	0	364	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,904	0	22,904	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	594	0	594	0	55.00
56.00	05600	RADIOISOTOPE	0	2,167	0	2,167	0	56.00
57.00	05700	CT SCAN	0	500	0	500	0	57.00
58.00	05800	MRI	0	3,709	0	3,709	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	17,829	0	17,829	0	59.00
60.00	06000	LABORATORY	0	15,311	0	15,311	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	887	0	887	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,607	0	5,607	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,142	0	2,142	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,658	0	1,658	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,104	0	2,104	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	888	0	888	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	4,876	0	4,876	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	682	0	682	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	891	0	891	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	1,455	0	1,455	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	4,527	0	4,527	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	14,829	0	14,829	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	328,809	24,979	317,099	24,979	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,043	0	4,043	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	22,546,766	1,757,528	3,911,878	2,759,848	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	67.738112	70.360223	12.181147	110.486729	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	4,112,864	298,463	160,349	354,229	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	12.356435	11.948557	0.499309	14.181072	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: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIREC T FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UI)	PHARMACY (COSTED REQ UI)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,331,479					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	37,176	0	1,194,682			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,598	0	0	8,956,190		14.00
15.00	01500	PHARMACY	0	0	0	57,961	10,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,432	0	0	11	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	17,114	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	15,057	0	0	292	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	334,459	0	526,179	826,569	0	30.00
31.00	03100	INTENSIVE CARE UNIT	87,398	0	98,076	427,084	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	23,979	0	24,608	40,000	0	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	48,413	0	63,816	15,522	0	40.00
41.00	04100	SUBPROVIDER - IRF	17,838	0	32,682	39,504	0	41.00
43.00	04300	NURSERY	11,917	0	14,640	27,206	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,554	0	85,008	484,072	0	50.00
50.01	03340	GI LAB	12,471	0	14,957	283,664	0	50.01
51.00	05100	RECOVERY ROOM	9,091	0	11,805	9,274	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,131	0	59,887	308,028	0	52.00
53.00	05300	ANESTHESIOLOGY	24,767	0	27,889	78,177	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,027	0	0	125,036	0	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	10,325	0	0	3,848	0	55.00
56.00	05600	RADIOISOTOPE	5,313	0	0	64,864	0	56.00
57.00	05700	CT SCAN	15,747	0	0	75,195	0	57.00
58.00	05800	MRI	3,686	0	0	6,566	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	34,866	0	49,340	85,526	0	59.00
60.00	06000	LABORATORY	109,057	0	0	2,812,875	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	30,314	0	38,070	23,840	0	65.00
66.00	06600	PHYSICAL THERAPY	20,304	0	0	604	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,231	0	0	1,890	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,173	0	0	303	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,586	0	0	1,486	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	978,858	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,491,699	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	10,303	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	5,035	0	0	5,907	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	3,986	0	5,790	13,303	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	8,495	0	0	5,493	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	281	0	0	0	0	76.08
76.09	03959	ADDP OP	4	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	2,253	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	8,052	0	0	11	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIREC T FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UI)	PHARMACY (COSTED REQ UI)	
			11.00	12.00	13.00	14.00	15.00	
76.97	07697	CARDIAC REHABILITATION	5,221	0	0	2,668	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	227,452	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	116,285	0	141,935	396,813	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,290,636	0	1,194,682	8,931,904	10,000	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	4,794	0	0	90	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,853	0	0	16,813	0	192.00
192.01	19201	DNBAR CLINIC	588	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	2,002	0	0	572	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	606	0	0	6,811	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	2,515,183	0	3,766,408	1,710,799	17,792,730	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.889014	0.000000	3.152645	0.191019	1,779.273000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	291,370	0	136,326	746,413	411,736	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.218832	0.000000	0.114111	0.083340	41.173600	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: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	384,530,823					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			9,245	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,059,685	0	0	0	5,429	30.00
31.00	03100	INTENSIVE CARE UNIT	11,806,368	0	0	0	364	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	5,653,100	0	0	0	268	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	6,894,662	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,325,778	0	0	0	0	41.00
43.00	04300	NURSERY	2,807,884	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,568,768	0	0	0	800	50.00
50.01	03340	GI LAB	3,790,087	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	1,450,004	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,147,391	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,886,842	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,395,891	0	0	0	1,225	54.00
54.01	05401	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	4,021,716	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	4,867,384	0	0	0	0	56.00
57.00	05700	CT SCAN	28,360,331	0	0	0	0	57.00
58.00	05800	MRI	6,036,474	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,596,730	0	0	0	0	59.00
60.00	06000	LABORATORY	75,194,800	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	7,380,404	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,433,984	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,476,480	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,141,580	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	158,747	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,416,690	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,615,072	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,613,809	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	772,401	0	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	540,400	0	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	495,514	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	2,175,977	0	0	0	0	76.06
76.07	03958	SLEEP LAB	1,497,108	0	0	0	0	76.07
76.08	03640	UROLOGY	200,000	0	0	0	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	274,343	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	71,730	0	0	0	0	76.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
76.12	03961	MENTAL HEALTH CENTER	276,077	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	334,471	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	1,116,570	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	39,675,571	0	0	0	1,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384,530,823	0	0	0	9,245	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DNBAR CLINIC	0	0	0	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	0	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	0	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	0	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	0	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
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)	2,905,742	0	0	0	4,150,509	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007557	0.000000	0.000000	0.000000	448.946349	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	210,385	0	0	0	335,106	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000547	0.000000	0.000000	0.000000	36.247269	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,245		22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)		100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,429	0	30.00
31.00	03100	INTENSIVE CARE UNIT	364	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	268	0	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	800	0	50.00
50.01	03340	GI LAB	0	0	50.01
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	1,225	0	54.00
54.01	05401	MRI CENTER	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03951	EMG	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	76.02
76.03	03954	MERCY ENT	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	76.06
76.07	03958	SLEEP LAB	0	0	76.07
76.08	03640	UROLOGY	0	0	76.08
76.09	03959	ADDP OP	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	76.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet B-1
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
76.12	03961	MENTAL HEALTH CENTER	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	MERCY CLINICS	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	90.03
91.00	09100	EMERGENCY	1,159	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,245	100	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	DNBAR CLINIC	0	0	192.01
192.02	19202	PHILLIPS HEALTH	0	0	192.02
192.03	19204	OTHER HOME HEALTH	0	0	192.03
192.04	19205	VITAS HOSPICE	0	0	192.04
192.05	19203	DOCTORS OFFICE	0	0	192.05
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	SENIOR FRIENDS	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03
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)	2,369,942	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	256.348513	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	136,104	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.721904	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet C Part I Date/Time Prepared: 11/1/2021 6:08 pm	
				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	34,910,358		34,910,358	0	34,910,358	30.00	
31.00	03100	INTENSIVE CARE UNIT	7,691,452		7,691,452	0	7,691,452	31.00	
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	2,598,656		2,598,656	0	2,598,656	32.01	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00	
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.01	
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.02	
40.00	04000	SUBPROVIDER - IPF	6,033,805		6,033,805	0	6,033,805	40.00	
41.00	04100	SUBPROVIDER - IRF	3,191,013		3,191,013	0	3,191,013	41.00	
43.00	04300	NURSERY	792,726		792,726	0	792,726	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,959,160		7,959,160	0	7,959,160	50.00	
50.01	03340	GI LAB	1,477,057		1,477,057	0	1,477,057	50.01	
51.00	05100	RECOVERY ROOM	1,066,620		1,066,620	0	1,066,620	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,267,647		6,267,647	0	6,267,647	52.00	
53.00	05300	ANESTHESIOLOGY	542,027		542,027	0	542,027	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,084,746		8,084,746	0	8,084,746	54.00	
54.01	05401	MRI CENTER	0		0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,203,594		1,203,594	0	1,203,594	55.00	
56.00	05600	RADIOISOTOPE	1,024,131		1,024,131	0	1,024,131	56.00	
57.00	05700	CT SCAN	1,571,489		1,571,489	0	1,571,489	57.00	
58.00	05800	MRI	752,689		752,689	0	752,689	58.00	
59.00	05900	CARDIAC CATHETERIZATION	8,464,134		8,464,134	0	8,464,134	59.00	
60.00	06000	LABORATORY	15,010,952		15,010,952	0	15,010,952	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	2,407,037	0	2,407,037	0	2,407,037	65.00	
66.00	06600	PHYSICAL THERAPY	2,087,978	0	2,087,978	0	2,087,978	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,032,100	0	1,032,100	0	1,032,100	67.00	
68.00	06800	SPEECH PATHOLOGY	558,191	0	558,191	0	558,191	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	294,588		294,588	0	294,588	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,059,618		3,059,618	0	3,059,618	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,403,613		4,403,613	0	4,403,613	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	18,122,320		18,122,320	0	18,122,320	73.00	
74.00	07400	RENAL DIALYSIS	816,865		816,865	0	816,865	74.00	
76.00	03951	EMG	0		0	0	0	76.00	
76.01	03952	CARDIOVASCULAR LAB	0		0	0	0	76.01	
76.02	03953	MERCY EYE CENTER	792,860		792,860	0	792,860	76.02	
76.03	03954	MERCY ENT	0		0	0	0	76.03	
76.04	03955	WOUND CARE CENTER	290,150		290,150	0	290,150	76.04	
76.05	03956	CARDIAC REHAB	0		0	0	0	76.05	
76.06	03957	PRE-BIRTH CENTER	715,659		715,659	0	715,659	76.06	
76.07	03958	SLEEP LAB	542,701		542,701	0	542,701	76.07	
76.08	03640	UROLOGY	114,233		114,233	0	114,233	76.08	
76.09	03959	ADDP OP	0		0	0	0	76.09	
76.10	03550	PSYCH PARTIAL HOSPITAL	149,370		149,370	0	149,370	76.10	
76.11	03960	DIABETES TREATMENT	216,840		216,840	0	216,840	76.11	
76.12	03961	MENTAL HEALTH CENTER	427,775		427,775	0	427,775	76.12	
76.13	03650	VEIN CLINIC	0		0	0	0	76.13	
76.97	07697	CARDIAC REHABILITATION	410,762		410,762	21,372	432,134	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS	9,255,785		9,255,785	0	9,255,785	90.01	
90.02	09002	MERCY CLINIC STATE ST	0		0	0	0	90.02	
90.03	09003	MERCY CLINIC POLK ST	0		0	0	0	90.03	
91.00	09100	EMERGENCY	22,917,155		22,917,155	0	22,917,155	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,107,822		4,107,822	0	4,107,822	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40	
200.00		Subtotal (see instructions)	181,365,678	0	181,365,678	21,372	181,387,050	200.00	
201.00		Less Observation Beds	4,107,822		4,107,822		4,107,822	201.00	
202.00		Total (see instructions)	177,257,856	0	177,257,856	21,372	177,279,228	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,646,551		44,646,551			30.00	
31.00	03100	INTENSIVE CARE UNIT	11,806,368		11,806,368			31.00	
32.00	03200	CORONARY CARE UNIT	0		0			32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	5,653,100		5,653,100			32.01	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00	
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0		0			34.01	
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0		0			34.02	
40.00	04000	SUBPROVIDER - IPF	6,894,662		6,894,662			40.00	
41.00	04100	SUBPROVIDER - IRF	3,325,778		3,325,778			41.00	
43.00	04300	NURSERY	2,807,884		2,807,884			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,454,065	9,114,703	13,568,768	0.586579	0.000000	50.00	
50.01	03340	GI LAB	698,323	3,091,764	3,790,087	0.389716	0.000000	50.01	
51.00	05100	RECOVERY ROOM	528,492	921,512	1,450,004	0.735598	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,822,240	325,151	7,147,391	0.876914	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	868,834	2,018,008	2,886,842	0.187758	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,110,807	22,285,084	29,395,891	0.275030	0.000000	54.00	
54.01	05401	MRI CENTER	0	0	0	0.000000	0.000000	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	243,074	3,778,642	4,021,716	0.299274	0.000000	55.00	
56.00	05600	RADIOISOTOPE	800,385	4,066,999	4,867,384	0.210407	0.000000	56.00	
57.00	05700	CT SCAN	9,588,766	18,771,565	28,360,331	0.055412	0.000000	57.00	
58.00	05800	MRI	1,710,586	4,325,888	6,036,474	0.124690	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	9,151,616	8,445,114	17,596,730	0.481006	0.000000	59.00	
60.00	06000	LABORATORY	35,247,636	39,947,164	75,194,800	0.199628	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	6,803,335	577,069	7,380,404	0.326139	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,452,882	981,102	2,433,984	0.857844	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,224,662	251,818	1,476,480	0.699027	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	789,957	351,623	1,141,580	0.488964	0.000000	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	113,970	44,777	158,747	1.855708	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,719,505	697,185	3,416,690	0.895492	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,674,838	1,940,234	3,615,072	1.218126	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	11,476,859	32,136,950	43,613,809	0.415518	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	751,970	20,431	772,401	1.057566	0.000000	74.00	
76.00	03951	EMG	0	0	0	0.000000	0.000000	76.00	
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0.000000	0.000000	76.01	
76.02	03953	MERCY EYE CENTER	0	540,400	540,400	1.467172	0.000000	76.02	
76.03	03954	MERCY ENT	0	0	0	0.000000	0.000000	76.03	
76.04	03955	WOUND CARE CENTER	2,216	493,298	495,514	0.585554	0.000000	76.04	
76.05	03956	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.05	
76.06	03957	PRE-BIRTH CENTER	96,955	2,079,022	2,175,977	0.328891	0.000000	76.06	
76.07	03958	SLEEP LAB	2,484	1,494,624	1,497,108	0.362500	0.000000	76.07	
76.08	03640	UROLOGY	0	200,000	200,000	0.571165	0.000000	76.08	
76.09	03959	ADDP OP	0	0	0	0.000000	0.000000	76.09	
76.10	03550	PSYCH PARTIAL HOSPITAL	0	274,343	274,343	0.544464	0.000000	76.10	
76.11	03960	DIABETES TREATMENT	0	71,730	71,730	3.023003	0.000000	76.11	
76.12	03961	MENTAL HEALTH CENTER	180	275,897	276,077	1.549477	0.000000	76.12	
76.13	03650	VEIN CLINIC	0	0	0	0.000000	0.000000	76.13	
76.97	07697	CARDIAC REHABILITATION	424	334,047	334,471	1.228095	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	1,116,570	1,116,570	8.289480	0.000000	90.01	
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0.000000	0.000000	90.02	
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0.000000	0.000000	90.03	
91.00	09100	EMERGENCY	10,176,206	29,499,365	39,675,571	0.577614	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	183,924	4,229,210	4,413,134	0.930817	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
200.00		Subtotal (see instructions)	189,829,534	194,701,289	384,530,823			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	189,829,534	194,701,289	384,530,823			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER				32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT				34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT				34.02
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.586579			50.00
50.01	03340	GI LAB	0.389716			50.01
51.00	05100	RECOVERY ROOM	0.735598			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.876914			52.00
53.00	05300	ANESTHESIOLOGY	0.187758			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275030			54.00
54.01	05401	MRI CENTER	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.299274			55.00
56.00	05600	RADIOISOTOPE	0.210407			56.00
57.00	05700	CT SCAN	0.055412			57.00
58.00	05800	MRI	0.124690			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.481006			59.00
60.00	06000	LABORATORY	0.199628			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.326139			65.00
66.00	06600	PHYSICAL THERAPY	0.857844			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.699027			67.00
68.00	06800	SPEECH PATHOLOGY	0.488964			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.855708			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.895492			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.218126			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415518			73.00
74.00	07400	RENAL DIALYSIS	1.057566			74.00
76.00	03951	EMG	0.000000			76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000			76.01
76.02	03953	MERCY EYE CENTER	1.467172			76.02
76.03	03954	MERCY ENT	0.000000			76.03
76.04	03955	WOUND CARE CENTER	0.585554			76.04
76.05	03956	CARDIAC REHAB	0.000000			76.05
76.06	03957	PRE-BIRTH CENTER	0.328891			76.06
76.07	03958	SLEEP LAB	0.362500			76.07
76.08	03640	UROLOGY	0.571165			76.08
76.09	03959	ADDP OP	0.000000			76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.544464			76.10
76.11	03960	DIABETES TREATMENT	3.023003			76.11
76.12	03961	MENTAL HEALTH CENTER	1.549477			76.12
76.13	03650	VEIN CLINIC	0.000000			76.13
76.97	07697	CARDIAC REHABILITATION	1.291992			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	8.289480			90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000			90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000			90.03
91.00	09100	EMERGENCY	0.577614			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930817			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	38,739,404		38,739,404	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	7,948,179		7,948,179	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	2,787,675		2,787,675	0	0	32.01	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00	
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.01	
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.02	
40.00	04000	SUBPROVIDER - IPF	6,033,805		6,033,805	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	3,191,013		3,191,013	0	0	41.00	
43.00	04300	NURSERY	792,726		792,726	0	0	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,523,396		8,523,396	0	0	50.00	
50.01	03340	GI LAB	1,477,057		1,477,057	0	0	50.01	
51.00	05100	RECOVERY ROOM	1,066,620		1,066,620	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,267,647		6,267,647	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	542,027		542,027	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,948,732		8,948,732	0	0	54.00	
54.01	05401	MRI CENTER	0		0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	1,203,594		1,203,594	0	0	55.00	
56.00	05600	RADIOISOTOPE	1,024,131		1,024,131	0	0	56.00	
57.00	05700	CT SCAN	1,571,489		1,571,489	0	0	57.00	
58.00	05800	MRI	752,689		752,689	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	8,464,134		8,464,134	0	0	59.00	
60.00	06000	LABORATORY	15,010,952		15,010,952	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	2,407,037	0	2,407,037	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	2,087,978	0	2,087,978	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,032,100	0	1,032,100	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	558,191	0	558,191	0	0	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	294,588		294,588	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,059,618		3,059,618	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,403,613		4,403,613	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	18,122,320		18,122,320	0	0	73.00	
74.00	07400	RENAL DIALYSIS	816,865		816,865	0	0	74.00	
76.00	03951	EMG	0		0	0	0	76.00	
76.01	03952	CARDIOVASCULAR LAB	0		0	0	0	76.01	
76.02	03953	MERCY EYE CENTER	792,860		792,860	0	0	76.02	
76.03	03954	MERCY ENT	0		0	0	0	76.03	
76.04	03955	WOUND CARE CENTER	290,150		290,150	0	0	76.04	
76.05	03956	CARDIAC REHAB	0		0	0	0	76.05	
76.06	03957	PRE-BIRTH CENTER	715,659		715,659	0	0	76.06	
76.07	03958	SLEEP LAB	542,701		542,701	0	0	76.07	
76.08	03640	UROLOGY	114,233		114,233	0	0	76.08	
76.09	03959	ADDP OP	0		0	0	0	76.09	
76.10	03550	PSYCH PARTIAL HOSPITAL	149,370		149,370	0	0	76.10	
76.11	03960	DIABETES TREATMENT	216,840		216,840	0	0	76.11	
76.12	03961	MENTAL HEALTH CENTER	427,775		427,775	0	0	76.12	
76.13	03650	VEIN CLINIC	0		0	0	0	76.13	
76.97	07697	CARDIAC REHABILITATION	410,762		410,762	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS	9,255,785		9,255,785	0	0	90.01	
90.02	09002	MERCY CLINIC STATE ST	0		0	0	0	90.02	
90.03	09003	MERCY CLINIC POLK ST	0		0	0	0	90.03	
91.00	09100	EMERGENCY	23,734,592		23,734,592	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,558,359		4,558,359	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40	
200.00		Subtotal (see instructions)	188,336,666	0	188,336,666	0	0	200.00	
201.00		Less Observation Beds	4,558,359		4,558,359		0	201.00	
202.00		Total (see instructions)	183,778,307	0	183,778,307	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0		0			32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0		0			34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0		0			34.02
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
50.01	03340	GI LAB	0	0	0	0.000000	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
54.01	05401	MRI CENTER	0	0	0	0.000000	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03951	EMG	0	0	0	0.000000	0.000000	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0.000000	0.000000	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	0.000000	0.000000	76.02
76.03	03954	MERCY ENT	0	0	0	0.000000	0.000000	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	0.000000	0.000000	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0.000000	0.000000	76.06
76.07	03958	SLEEP LAB	0	0	0	0.000000	0.000000	76.07
76.08	03640	UROLOGY	0	0	0	0.000000	0.000000	76.08
76.09	03959	ADDP OP	0	0	0	0.000000	0.000000	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0.000000	0.000000	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0.000000	0.000000	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0.000000	0.000000	76.12
76.13	03650	VEIN CLINIC	0	0	0	0.000000	0.000000	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	0	0	0	0.000000	0.000000	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0.000000	0.000000	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
32.00	03200	CORONARY CARE UNIT				32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER				32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT				34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT				34.02
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
50.01	03340	GI LAB	0.000000			50.01
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	MRI CENTER	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03951	EMG	0.000000			76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000			76.01
76.02	03953	MERCY EYE CENTER	0.000000			76.02
76.03	03954	MERCY ENT	0.000000			76.03
76.04	03955	WOUND CARE CENTER	0.000000			76.04
76.05	03956	CARDIAC REHAB	0.000000			76.05
76.06	03957	PRE-BIRTH CENTER	0.000000			76.06
76.07	03958	SLEEP LAB	0.000000			76.07
76.08	03640	UROLOGY	0.000000			76.08
76.09	03959	ADDP OP	0.000000			76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.000000			76.10
76.11	03960	DIABETES TREATMENT	0.000000			76.11
76.12	03961	MENTAL HEALTH CENTER	0.000000			76.12
76.13	03650	VEIN CLINIC	0.000000			76.13
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	0.000000			90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000			90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000			90.03
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet D
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Title XVIII		Hospital	PPS		
		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	3,841,661	0	3,841,661	20,133	190.81	30.00
31.00	INTENSIVE CARE UNIT	609,588		609,588	3,319	183.67	31.00
32.00	CORONARY CARE UNIT	686		686	0	0.00	32.00
32.01	NURSERY INTENSIVE CARE CENTER	131,714		131,714	1,264	104.20	32.01
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
34.01	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.01
34.02	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.02
40.00	SUBPROVIDER - IPF	602,379	0	602,379	3,443	174.96	40.00
41.00	SUBPROVIDER - IRF	296,769	0	296,769	1,645	180.41	41.00
43.00	NURSERY	46,582		46,582	1,532	30.41	43.00
200.00	Total (lines 30 through 199)	5,529,379		5,529,379	31,336		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	5,151	982,862				30.00
31.00	INTENSIVE CARE UNIT	1,036	190,282				31.00
32.00	CORONARY CARE UNIT	0	0				32.00
32.01	NURSERY INTENSIVE CARE CENTER	0	0				32.01
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01	SURGICAL INTENSIVE CARE UNIT	0	0				34.01
34.02	SURGICAL INTENSIVE CARE UNIT	0	0				34.02
40.00	SUBPROVIDER - IPF	406	71,034				40.00
41.00	SUBPROVIDER - IRF	937	169,044				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	7,530	1,413,222				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet D
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			Title XVIII		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	2,226,824	13,568,768	0.164114	838,968	137,686	50.00
50.01	03340	GI LAB	258,568	3,790,087	0.068222	214,885	14,660	50.01
51.00	05100	RECOVERY ROOM	102,799	1,450,004	0.070896	135,746	9,624	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	648,655	7,147,391	0.090754	0	0	52.00
53.00	05300	ANESTHESIOLOGY	44,044	2,886,842	0.015257	155,245	2,369	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,659	29,395,891	0.032646	2,077,025	67,807	54.00
54.01	05401	MRI CENTER	0	0	0.000000	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	49,287	4,021,716	0.012255	36,857	452	55.00
56.00	05600	RADIOISOTOPE	94,161	4,867,384	0.019345	261,056	5,050	56.00
57.00	05700	CT SCAN	71,652	28,360,331	0.002526	3,035,881	7,669	57.00
58.00	05800	MRI	1,055,782	6,036,474	0.174900	490,227	85,741	58.00
59.00	05900	CARDIAC CATHETERIZATION	713,319	17,596,730	0.040537	2,480,135	100,537	59.00
60.00	06000	LABORATORY	1,050,878	75,194,800	0.013975	8,940,355	124,941	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	136,819	7,380,404	0.018538	1,806,494	33,489	65.00
66.00	06600	PHYSICAL THERAPY	208,027	2,433,984	0.085468	324,778	27,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,648	1,476,480	0.058008	222,077	12,882	67.00
68.00	06800	SPEECH PATHOLOGY	59,929	1,141,580	0.052497	188,930	9,918	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,619	158,747	0.419655	32,719	13,731	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148,394	3,416,690	0.043432	918,237	39,881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,635	3,615,072	0.060755	347,527	21,114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435,593	43,613,809	0.009988	3,162,268	31,585	73.00
74.00	07400	RENAL DIALYSIS	47,448	772,401	0.061429	286,021	17,570	74.00
76.00	03951	EMG	0	0	0.000000	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	0	76.01
76.02	03953	MERCY EYE CENTER	156,904	540,400	0.290348	0	0	76.02
76.03	03954	MERCY ENT	0	0	0.000000	0	0	76.03
76.04	03955	WOUND CARE CENTER	47,909	495,514	0.096685	1,680	162	76.04
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	19,334	2,175,977	0.008885	0	0	76.06
76.07	03958	SLEEP LAB	12,942	1,497,108	0.008645	0	0	76.07
76.08	03640	UROLOGY	35,535	200,000	0.177675	0	0	76.08
76.09	03959	ADDP OP	0	0	0.000000	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	43,563	274,343	0.158790	0	0	76.10
76.11	03960	DIABETES TREATMENT	5,466	71,730	0.076202	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	11,450	276,077	0.041474	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0.000000	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	10,827	334,471	0.032371	350	11	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	779,649	1,116,570	0.698254	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	1,037,429	39,675,571	0.026148	2,587,116	67,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	452,041	4,413,134	0.102431	176,160	18,044	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	11,296,789	309,396,480		28,720,737	850,329	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part III Date/Time Prepared: 11/1/2021 6:08 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School	Nursing School	Allied Health	Allied Health	All Other Medical Education Cost				
			Post-Stepdown Adjustments		Post-Stepdown Adjustments	Cost					
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	0	32.00		
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	0	0	0	0	32.01		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00		
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.01		
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.02		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	20,133	0.00	5,151	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	3,319	0.00	1,036	31.00			
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00			
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	1,264	0.00	0	32.01			
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00			
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.01			
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.02			
40.00	04000	SUBPROVIDER - IPF	0	0	3,443	0.00	406	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	1,645	0.00	937	41.00			
43.00	04300	NURSERY	0	0	1,532	0.00	0	43.00			
200.00		Total (lines 30 through 199)	0	0	31,336	0.00	7,530	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
32.00	03200	CORONARY CARE UNIT	0								32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER	0								32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0								34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0								34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0								34.02
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	03340	GI LAB	0	0	0	0	0	50.01
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	MRI CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03951	EMG	0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	0	0	76.02
76.03	03954	MERCY ENT	0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0	0	76.06
76.07	03958	SLEEP LAB	0	0	0	0	0	76.07
76.08	03640	UROLOGY	0	0	0	0	0	76.08
76.09	03959	ADDP OP	0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC	0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	MERCY CLINICS	0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			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	13,568,768	0.000000
50.01	03340	GI LAB	0	0	0	3,790,087	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	1,450,004	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,147,391	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	2,886,842	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,395,891	0.000000
54.01	05401	MRI CENTER	0	0	0	0	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,021,716	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	4,867,384	0.000000
57.00	05700	CT SCAN	0	0	0	28,360,331	0.000000
58.00	05800	MRI	0	0	0	6,036,474	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,596,730	0.000000
60.00	06000	LABORATORY	0	0	0	75,194,800	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,380,404	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,433,984	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,476,480	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,141,580	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	158,747	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,416,690	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,615,072	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,613,809	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	772,401	0.000000
76.00	03951	EMG	0	0	0	0	0.000000
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0.000000
76.02	03953	MERCY EYE CENTER	0	0	0	540,400	0.000000
76.03	03954	MERCY ENT	0	0	0	0	0.000000
76.04	03955	WOUND CARE CENTER	0	0	0	495,514	0.000000
76.05	03956	CARDIAC REHAB	0	0	0	0	0.000000
76.06	03957	PRE-BIRTH CENTER	0	0	0	2,175,977	0.000000
76.07	03958	SLEEP LAB	0	0	0	1,497,108	0.000000
76.08	03640	UROLOGY	0	0	0	200,000	0.000000
76.09	03959	ADDP OP	0	0	0	0	0.000000
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	274,343	0.000000
76.11	03960	DIABETES TREATMENT	0	0	0	71,730	0.000000
76.12	03961	MENTAL HEALTH CENTER	0	0	0	276,077	0.000000
76.13	03650	VEIN CLINIC	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	334,471	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	0	0	0	1,116,570	0.000000
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0.000000
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	39,675,571	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,413,134	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	309,396,480	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
Provider CCN: 14-0158
Period: From 07/01/2020 To 05/31/2021
Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	838,968	0	1,880,398	0	50.00	
50.01	03340 GI LAB	0.000000	214,885	0	544,659	0	50.01	
51.00	05100 RECOVERY ROOM	0.000000	135,746	0	116,051	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	853	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	155,245	0	286,085	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,077,025	0	2,073,152	0	54.00	
54.01	05401 MRI CENTER	0.000000	0	0	0	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	36,857	0	724,944	0	55.00	
56.00	05600 RADIOISOTOPE	0.000000	261,056	0	969,955	0	56.00	
57.00	05700 CT SCAN	0.000000	3,035,881	0	3,352,724	0	57.00	
58.00	05800 MRI	0.000000	490,227	0	804,826	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	2,480,135	0	1,871,192	0	59.00	
60.00	06000 LABORATORY	0.000000	8,940,355	0	2,203,652	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	1,806,494	0	151,976	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	324,778	0	2,352	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	222,077	0	2,016	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	188,930	0	29,059	0	68.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	32,719	0	11,722	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	918,237	0	136,014	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	347,527	0	519,571	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	3,162,268	0	8,413,451	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	286,021	0	14,336	0	74.00	
76.00	03951 EMG	0.000000	0	0	0	0	76.00	
76.01	03952 CARDIOVASCULAR LAB	0.000000	0	0	0	0	76.01	
76.02	03953 MERCY EYE CENTER	0.000000	0	0	207,831	0	76.02	
76.03	03954 MERCY ENT	0.000000	0	0	0	0	76.03	
76.04	03955 WOUND CARE CENTER	0.000000	1,680	0	130,011	0	76.04	
76.05	03956 CARDIAC REHAB	0.000000	0	0	0	0	76.05	
76.06	03957 PRE-BIRTH CENTER	0.000000	0	0	0	0	76.06	
76.07	03958 SLEEP LAB	0.000000	0	0	152,537	0	76.07	
76.08	03640 UROLOGY	0.000000	0	0	0	0	76.08	
76.09	03959 ADDP OP	0.000000	0	0	0	0	76.09	
76.10	03550 PSYCH PARTIAL HOSPITAL	0.000000	0	0	19,571	0	76.10	
76.11	03960 DIABETES TREATMENT	0.000000	0	0	3,278	0	76.11	
76.12	03961 MENTAL HEALTH CENTER	0.000000	0	0	80,782	0	76.12	
76.13	03650 VEIN CLINIC	0.000000	0	0	0	0	76.13	
76.97	07697 CARDIAC REHABILITATION	0.000000	350	0	61,952	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 MERCY CLINICS	0.000000	0	0	17,457	0	90.01	
90.02	09002 MERCY CLINIC STATE ST	0.000000	0	0	0	0	90.02	
90.03	09003 MERCY CLINIC POLK ST	0.000000	0	0	0	0	90.03	
91.00	09100 EMERGENCY	0.000000	2,587,116	0	2,675,294	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	176,160	0	634,903	0	92.00	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00	Total (lines 50 through 199)		28,720,737	0	28,092,604	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part V Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.586579	1,880,398	0	0	1,103,002	50.00
50.01	03340	GI LAB		0.389716	544,659	0	0	212,262	50.01
51.00	05100	RECOVERY ROOM		0.735598	116,051	0	0	85,367	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.876914	853	0	0	748	52.00
53.00	05300	ANESTHESIOLOGY		0.187758	286,085	0	0	53,715	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.275030	2,073,152	0	0	570,179	54.00
54.01	05401	MRI CENTER		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.299274	724,944	0	0	216,957	55.00
56.00	05600	RADIOISOTOPE		0.210407	969,955	0	0	204,085	56.00
57.00	05700	CT SCAN		0.055412	3,352,724	0	0	185,781	57.00
58.00	05800	MRI		0.124690	804,826	0	0	100,354	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.481006	1,871,192	0	0	900,055	59.00
60.00	06000	LABORATORY		0.199628	2,203,652	0	0	439,911	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.326139	151,976	0	0	49,565	65.00
66.00	06600	PHYSICAL THERAPY		0.857844	2,352	0	0	2,018	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.699027	2,016	0	0	1,409	67.00
68.00	06800	SPEECH PATHOLOGY		0.488964	29,059	0	0	14,209	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		1.855708	11,722	0	0	21,753	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.895492	136,014	0	0	121,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		1.218126	519,571	0	0	632,903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.415518	8,413,451	0	0	3,495,940	73.00
74.00	07400	RENAL DIALYSIS		1.057566	14,336	0	0	15,161	74.00
76.00	03951	EMG		0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		1.467172	207,831	0	0	304,924	76.02
76.03	03954	MERCY ENT		0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0.585554	130,011	0	0	76,128	76.04
76.05	03956	CARDIAC REHAB		0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0.328891	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0.362500	152,537	0	0	55,295	76.07
76.08	03640	UROLOGY		0.571165	0	0	0	0	76.08
76.09	03959	ADDP OP		0.000000	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0.544464	19,571	0	0	10,656	76.10
76.11	03960	DIABETES TREATMENT		3.023003	3,278	0	0	9,909	76.11
76.12	03961	MENTAL HEALTH CENTER		1.549477	80,782	0	0	125,170	76.12
76.13	03650	VEIN CLINIC		0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		1.228095	61,952	0	0	76,083	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		8.289480	17,457	0	0	144,709	90.01
90.02	09002	MERCY CLINIC STATE ST		0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.577614	2,675,294	0	0	1,545,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.930817	634,903	0	0	590,979	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)			28,092,604	0	0	11,366,313	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			28,092,604	0	0	11,366,313	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021	Worksheet D Part V Date/Time Prepared: 11/1/2021 6:08 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	03340	GI LAB	0	0		50.01
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	MRI CENTER	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03951	EMG	0	0		76.00
76.01	03952	CARDIOVASCULAR LAB	0	0		76.01
76.02	03953	MERCY EYE CENTER	0	0		76.02
76.03	03954	MERCY ENT	0	0		76.03
76.04	03955	WOUND CARE CENTER	0	0		76.04
76.05	03956	CARDIAC REHAB	0	0		76.05
76.06	03957	PRE-BIRTH CENTER	0	0		76.06
76.07	03958	SLEEP LAB	0	0		76.07
76.08	03640	UROLOGY	0	0		76.08
76.09	03959	ADDP OP	0	0		76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0		76.10
76.11	03960	DIABETES TREATMENT	0	0		76.11
76.12	03961	MENTAL HEALTH CENTER	0	0		76.12
76.13	03650	VEIN CLINIC	0	0		76.13
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	0	0		90.01
90.02	09002	MERCY CLINIC STATE ST	0	0		90.02
90.03	09003	MERCY CLINIC POLK ST	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:

Worksheet D

Component CCN: 14-S158

From 07/01/2020
To 05/31/2021Part II
Date/Time Prepared:
11/1/2021 6:08 pm

				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,226,824	13,568,768	0.164114	0	0	50.00	
50.01	03340	GI LAB	258,568	3,790,087	0.068222	0	0	50.01	
51.00	05100	RECOVERY ROOM	102,799	1,450,004	0.070896	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	648,655	7,147,391	0.090754	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	44,044	2,886,842	0.015257	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,659	29,395,891	0.032646	4,700	153	54.00	
54.01	05401	MRI CENTER	0	0	0.000000	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	49,287	4,021,716	0.012255	0	0	55.00	
56.00	05600	RADIOISOTOPE	94,161	4,867,384	0.019345	0	0	56.00	
57.00	05700	CT SCAN	71,652	28,360,331	0.002526	19,918	50	57.00	
58.00	05800	MRI	1,055,782	6,036,474	0.174900	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	713,319	17,596,730	0.040537	11,494	466	59.00	
60.00	06000	LABORATORY	1,050,878	75,194,800	0.013975	144,912	2,025	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	136,819	7,380,404	0.018538	376	7	65.00	
66.00	06600	PHYSICAL THERAPY	208,027	2,433,984	0.085468	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	85,648	1,476,480	0.058008	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	59,929	1,141,580	0.052497	0	0	68.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	66,619	158,747	0.419655	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148,394	3,416,690	0.043432	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,635	3,615,072	0.060755	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	435,593	43,613,809	0.009988	30,123	301	73.00	
74.00	07400	RENAL DIALYSIS	47,448	772,401	0.061429	0	0	74.00	
76.00	03951	EMG	0	0	0.000000	0	0	76.00	
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	0	76.01	
76.02	03953	MERCY EYE CENTER	156,904	540,400	0.290348	0	0	76.02	
76.03	03954	MERCY ENT	0	0	0.000000	0	0	76.03	
76.04	03955	WOUND CARE CENTER	47,909	495,514	0.096685	0	0	76.04	
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	0	76.05	
76.06	03957	PRE-BIRTH CENTER	19,334	2,175,977	0.008885	0	0	76.06	
76.07	03958	SLEEP LAB	12,942	1,497,108	0.008645	0	0	76.07	
76.08	03640	UROLOGY	35,535	200,000	0.177675	0	0	76.08	
76.09	03959	ADDP OP	0	0	0.000000	0	0	76.09	
76.10	03550	PSYCH PARTIAL HOSPITAL	43,563	274,343	0.158790	0	0	76.10	
76.11	03960	DIABETES TREATMENT	5,466	71,730	0.076202	0	0	76.11	
76.12	03961	MENTAL HEALTH CENTER	11,450	276,077	0.041474	0	0	76.12	
76.13	03650	VEIN CLINIC	0	0	0.000000	0	0	76.13	
76.97	07697	CARDIAC REHABILITATION	10,827	334,471	0.032371	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS	779,649	1,116,570	0.698254	0	0	90.01	
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	0	90.02	
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	0	90.03	
91.00	09100	EMERGENCY	1,037,429	39,675,571	0.026148	107,240	2,804	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,413,134	0.000000	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99	
200.00		Total (lines 50 through 199)	10,844,748	309,396,480		318,763	5,806	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	03340	GI LAB		0	0	0	0	0	50.01
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	MRI CENTER		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03951	EMG		0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	0	0	76.02
76.03	03954	MERCY ENT		0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0	0	0	0	0	76.07
76.08	03640	UROLOGY		0	0	0	0	0	76.08
76.09	03959	ADDP OP		0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
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: 14-0158 Component CCN: 14-S158		Period: From 07/01/2020 To 05/31/2021	Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8) Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				4.00	5.00	6.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	13,568,768	0.000000
50.01	03340	GI LAB	0	0	0	3,790,087	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	1,450,004	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,147,391	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	2,886,842	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,395,891	0.000000
54.01	05401	MRI CENTER	0	0	0	0	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	4,021,716	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	4,867,384	0.000000
57.00	05700	CT SCAN	0	0	0	28,360,331	0.000000
58.00	05800	MRI	0	0	0	6,036,474	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,596,730	0.000000
60.00	06000	LABORATORY	0	0	0	75,194,800	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,380,404	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,433,984	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,476,480	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,141,580	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	158,747	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,416,690	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,615,072	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,613,809	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	772,401	0.000000
76.00	03951	EMG	0	0	0	0	0.000000
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0	0.000000
76.02	03953	MERCY EYE CENTER	0	0	0	540,400	0.000000
76.03	03954	MERCY ENT	0	0	0	0	0.000000
76.04	03955	WOUND CARE CENTER	0	0	0	495,514	0.000000
76.05	03956	CARDIAC REHAB	0	0	0	0	0.000000
76.06	03957	PRE-BIRTH CENTER	0	0	0	2,175,977	0.000000
76.07	03958	SLEEP LAB	0	0	0	1,497,108	0.000000
76.08	03640	UROLOGY	0	0	0	200,000	0.000000
76.09	03959	ADDP OP	0	0	0	0	0.000000
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	274,343	0.000000
76.11	03960	DIABETES TREATMENT	0	0	0	71,730	0.000000
76.12	03961	MENTAL HEALTH CENTER	0	0	0	276,077	0.000000
76.13	03650	VEIN CLINIC	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	334,471	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	0	0	0	1,116,570	0.000000
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0	0.000000
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	39,675,571	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,413,134	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	309,396,480	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
50.01	03340	GI LAB		0.000000	0	0	0	0	50.01
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	4,700	0	0	0	54.00
54.01	05401	MRI CENTER		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	19,918	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	11,494	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	144,912	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	376	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
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
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	30,123	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03951	EMG		0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0.000000	0	0	0	0	76.02
76.03	03954	MERCY ENT		0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0.000000	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0.000000	0	0	0	0	76.07
76.08	03640	UROLOGY		0.000000	0	0	0	0	76.08
76.09	03959	ADDP OP		0.000000	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0.000000	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0.000000	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0.000000	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0.000000	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.000000	107,240	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			318,763	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:

Worksheet D

Component CCN: 14-T158

From 07/01/2020

Part II

To 05/31/2021

Date/Time Prepared:
11/1/2021 6:08 pm

			Title XVIII		Subprovider - IRF	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	2,226,824	13,568,768	0.164114	4,615	757
50.01	03340	GI LAB	258,568	3,790,087	0.068222	0	0
51.00	05100	RECOVERY ROOM	102,799	1,450,004	0.070896	509	36
52.00	05200	DELIVERY ROOM & LABOR ROOM	648,655	7,147,391	0.090754	0	0
53.00	05300	ANESTHESIOLOGY	44,044	2,886,842	0.015257	524	8
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,659	29,395,891	0.032646	3,372	110
54.01	05401	MRI CENTER	0	0	0.000000	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	49,287	4,021,716	0.012255	0	0
56.00	05600	RADIOISOTOPE	94,161	4,867,384	0.019345	0	0
57.00	05700	CT SCAN	71,652	28,360,331	0.002526	5,941	15
58.00	05800	MRI	1,055,782	6,036,474	0.174900	0	0
59.00	05900	CARDIAC CATHETERIZATION	713,319	17,596,730	0.040537	7,592	308
60.00	06000	LABORATORY	1,050,878	75,194,800	0.013975	228,956	3,200
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	136,819	7,380,404	0.018538	12,977	241
66.00	06600	PHYSICAL THERAPY	208,027	2,433,984	0.085468	356,302	30,452
67.00	06700	OCCUPATIONAL THERAPY	85,648	1,476,480	0.058008	369,610	21,440
68.00	06800	SPEECH PATHOLOGY	59,929	1,141,580	0.052497	159,401	8,368
70.00	07000	ELECTROENCEPHALOGRAPHY	66,619	158,747	0.419655	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148,394	3,416,690	0.043432	9,985	434
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,635	3,615,072	0.060755	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	435,593	43,613,809	0.009988	96,337	962
74.00	07400	RENAL DIALYSIS	47,448	772,401	0.061429	39,526	2,428
76.00	03951	EMG	0	0	0.000000	0	0
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	0
76.02	03953	MERCY EYE CENTER	156,904	540,400	0.290348	0	0
76.03	03954	MERCY ENT	0	0	0.000000	0	0
76.04	03955	WOUND CARE CENTER	47,909	495,514	0.096685	0	0
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	0
76.06	03957	PRE-BIRTH CENTER	19,334	2,175,977	0.008885	0	0
76.07	03958	SLEEP LAB	12,942	1,497,108	0.008645	0	0
76.08	03640	UROLOGY	35,535	200,000	0.177675	0	0
76.09	03959	ADDP OP	0	0	0.000000	0	0
76.10	03550	PSYCH PARTIAL HOSPITAL	43,563	274,343	0.158790	0	0
76.11	03960	DIABETES TREATMENT	5,466	71,730	0.076202	0	0
76.12	03961	MENTAL HEALTH CENTER	11,450	276,077	0.041474	0	0
76.13	03650	VEIN CLINIC	0	0	0.000000	0	0
76.97	07697	CARDIAC REHABILITATION	10,827	334,471	0.032371	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
	OUTPATIENT SERVICE COST CENTERS						
90.01	09001	MERCY CLINICS	779,649	1,116,570	0.698254	0	0
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	0
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	0
91.00	09100	EMERGENCY	1,037,429	39,675,571	0.026148	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,413,134	0.000000	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	10,844,748	309,396,480		1,295,647	68,759

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	03340	GI LAB		0	0	0	0	0	50.01
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	MRI CENTER		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03951	EMG		0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	0	0	76.02
76.03	03954	MERCY ENT		0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0	0	0	0	0	76.07
76.08	03640	UROLOGY		0	0	0	0	0	76.08
76.09	03959	ADDP OP		0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
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: 14-0158 Component CCN: 14-T158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IRF		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	13,568,768	0.000000	50.00
50.01	03340	GI LAB		0	0	0	3,790,087	0.000000	50.01
51.00	05100	RECOVERY ROOM		0	0	0	1,450,004	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	7,147,391	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	2,886,842	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	29,395,891	0.000000	54.00
54.01	05401	MRI CENTER		0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	4,021,716	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	4,867,384	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	28,360,331	0.000000	57.00
58.00	05800	MRI		0	0	0	6,036,474	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	17,596,730	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	75,194,800	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	7,380,404	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,433,984	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,476,480	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,141,580	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	158,747	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	3,416,690	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	3,615,072	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	43,613,809	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	772,401	0.000000	74.00
76.00	03951	EMG		0	0	0	0	0.000000	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0.000000	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	540,400	0.000000	76.02
76.03	03954	MERCY ENT		0	0	0	0	0.000000	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	495,514	0.000000	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0.000000	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	2,175,977	0.000000	76.06
76.07	03958	SLEEP LAB		0	0	0	1,497,108	0.000000	76.07
76.08	03640	UROLOGY		0	0	0	200,000	0.000000	76.08
76.09	03959	ADDP OP		0	0	0	0	0.000000	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	274,343	0.000000	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	71,730	0.000000	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	276,077	0.000000	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0.000000	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	334,471	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	1,116,570	0.000000	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0.000000	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	39,675,571	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	4,413,134	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)		0	0	0	309,396,480		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IRF		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	4,615	0	0	0	50.00
50.01	03340	GI LAB		0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	509	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	524	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	3,372	0	0	0	54.00
54.01	05401	MRI CENTER		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	5,941	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	7,592	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	228,956	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	12,977	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	356,302	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	369,610	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	159,401	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	9,985	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	96,337	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	39,526	0	0	0	74.00
76.00	03951	EMG		0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0.000000	0	0	0	0	76.02
76.03	03954	MERCY ENT		0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0.000000	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0.000000	0	0	0	0	76.07
76.08	03640	UROLOGY		0.000000	0	0	0	0	76.08
76.09	03959	ADDP OP		0.000000	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0.000000	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0.000000	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0.000000	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0.000000	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0.000000	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			1,295,647	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet D
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Title XIX			Hospital	Cost	
		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	3,841,661	0	3,841,661	20,133	190.81	30.00
31.00	INTENSIVE CARE UNIT	609,588		609,588	3,319	183.67	31.00
32.00	CORONARY CARE UNIT	686		686	0	0.00	32.00
32.01	NURSERY INTENSIVE CARE CENTER	131,714		131,714	1,264	104.20	32.01
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
34.01	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.01
34.02	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.02
40.00	SUBPROVIDER - IPF	602,379	0	602,379	3,443	174.96	40.00
41.00	SUBPROVIDER - IRF	296,769	0	296,769	1,645	180.41	41.00
43.00	NURSERY	46,582		46,582	1,532	30.41	43.00
200.00	Total (lines 30 through 199)	5,529,379		5,529,379	31,336		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	724	138,146				30.00
31.00	INTENSIVE CARE UNIT	300	55,101				31.00
32.00	CORONARY CARE UNIT	0	0				32.00
32.01	NURSERY INTENSIVE CARE CENTER	500	52,100				32.01
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01	SURGICAL INTENSIVE CARE UNIT	0	0				34.01
34.02	SURGICAL INTENSIVE CARE UNIT	0	0				34.02
40.00	SUBPROVIDER - IPF	274	47,939				40.00
41.00	SUBPROVIDER - IRF	81	14,613				41.00
43.00	NURSERY	500	15,205				43.00
200.00	Total (lines 30 through 199)	2,379	323,104				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet D
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,226,824	0	0.000000	0	0 50.00
50.01	03340	GI LAB	258,568	0	0.000000	0	0 50.01
51.00	05100	RECOVERY ROOM	102,799	0	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	648,655	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	44,044	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,659	0	0.000000	0	0 54.00
54.01	05401	MRI CENTER	0	0	0.000000	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	49,287	0	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	94,161	0	0.000000	0	0 56.00
57.00	05700	CT SCAN	71,652	0	0.000000	0	0 57.00
58.00	05800	MRI	1,055,782	0	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	713,319	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	1,050,878	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	136,819	0	0.000000	0	0 65.00
66.00	06600	PHYSICAL THERAPY	208,027	0	0.000000	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	85,648	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	59,929	0	0.000000	0	0 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	66,619	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148,394	0	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,635	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	435,593	0	0.000000	0	0 73.00
74.00	07400	RENAL DIALYSIS	47,448	0	0.000000	0	0 74.00
76.00	03951	EMG	0	0	0.000000	0	0 76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0.000000	0	0 76.01
76.02	03953	MERCY EYE CENTER	156,904	0	0.000000	0	0 76.02
76.03	03954	MERCY ENT	0	0	0.000000	0	0 76.03
76.04	03955	WOUND CARE CENTER	47,909	0	0.000000	0	0 76.04
76.05	03956	CARDIAC REHAB	0	0	0.000000	0	0 76.05
76.06	03957	PRE-BIRTH CENTER	19,334	0	0.000000	0	0 76.06
76.07	03958	SLEEP LAB	12,942	0	0.000000	0	0 76.07
76.08	03640	UROLOGY	35,535	0	0.000000	0	0 76.08
76.09	03959	ADDP OP	0	0	0.000000	0	0 76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	43,563	0	0.000000	0	0 76.10
76.11	03960	DIABETES TREATMENT	5,466	0	0.000000	0	0 76.11
76.12	03961	MENTAL HEALTH CENTER	11,450	0	0.000000	0	0 76.12
76.13	03650	VEIN CLINIC	0	0	0.000000	0	0 76.13
76.97	07697	CARDIAC REHABILITATION	10,827	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	779,649	0	0.000000	0	0 90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0.000000	0	0 90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0.000000	0	0 90.03
91.00	09100	EMERGENCY	1,037,429	0	0.000000	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	452,039	0	0.000000	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0 93.99
200.00		Total (lines 50 through 199)	11,296,787	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part III Date/Time Prepared: 11/1/2021 6:08 pm	
					Title XIX		Hospital		Cost	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	0	32.00	
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	0	0	0	0	32.01	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00	
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.01	
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.02	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days		
			4.00	5.00	6.00	7.00		8.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	20,133	0.00	724	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	3,319	0.00	300	31.00		
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	32.00		
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	0	1,264	0.00	500	32.01		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.00		
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.01		
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	34.02		
40.00	04000	SUBPROVIDER - IPF	0	0	3,443	0.00	274	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	1,645	0.00	81	41.00		
43.00	04300	NURSERY	0	0	1,532	0.00	500	43.00		
200.00		Total (lines 30 through 199)	0	0	31,336		2,379	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						
32.00	03200	CORONARY CARE UNIT	0	32.00						
32.01	02060	NURSERY INTENSIVE CARE CENTER	0	32.01						
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00						
34.01	03401	SURGICAL INTENSIVE CARE UNIT	0	34.01						
34.02	03402	SURGICAL INTENSIVE CARE UNIT	0	34.02						
40.00	04000	SUBPROVIDER - IPF	0	40.00						
41.00	04100	SUBPROVIDER - IRF	0	41.00						
43.00	04300	NURSERY	0	43.00						
200.00		Total (lines 30 through 199)	0	200.00						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XIX		Hospital		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
50.01	03340	GI LAB		0	0	0	0	0	50.01
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	MRI CENTER		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03951	EMG		0	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0	0	0	0	0	76.02
76.03	03954	MERCY ENT		0	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0	0	0	0	0	76.07
76.08	03640	UROLOGY		0	0	0	0	0	76.08
76.09	03959	ADDP OP		0	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Title XIX		Hospital		Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	50.00
50.01	03340	GI LAB	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
54.01	05401	MRI CENTER	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03951	EMG	0	0	0	0.000000	76.00
76.01	03952	CARDIOVASCULAR LAB	0	0	0	0.000000	76.01
76.02	03953	MERCY EYE CENTER	0	0	0	0.000000	76.02
76.03	03954	MERCY ENT	0	0	0	0.000000	76.03
76.04	03955	WOUND CARE CENTER	0	0	0	0.000000	76.04
76.05	03956	CARDIAC REHAB	0	0	0	0.000000	76.05
76.06	03957	PRE-BIRTH CENTER	0	0	0	0.000000	76.06
76.07	03958	SLEEP LAB	0	0	0	0.000000	76.07
76.08	03640	UROLOGY	0	0	0	0.000000	76.08
76.09	03959	ADDP OP	0	0	0	0.000000	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0	0	0	0.000000	76.10
76.11	03960	DIABETES TREATMENT	0	0	0	0.000000	76.11
76.12	03961	MENTAL HEALTH CENTER	0	0	0	0.000000	76.12
76.13	03650	VEIN CLINIC	0	0	0	0.000000	76.13
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	MERCY CLINICS	0	0	0	0.000000	90.01
90.02	09002	MERCY CLINIC STATE ST	0	0	0	0.000000	90.02
90.03	09003	MERCY CLINIC POLK ST	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XIX		Hospital		Cost	
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
50.01	03340	GI LAB		0.000000	0	0	0	0	50.01
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	MRI CENTER		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
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
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
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	03951	EMG		0.000000	0	0	0	0	76.00
76.01	03952	CARDIOVASCULAR LAB		0.000000	0	0	0	0	76.01
76.02	03953	MERCY EYE CENTER		0.000000	0	0	0	0	76.02
76.03	03954	MERCY ENT		0.000000	0	0	0	0	76.03
76.04	03955	WOUND CARE CENTER		0.000000	0	0	0	0	76.04
76.05	03956	CARDIAC REHAB		0.000000	0	0	0	0	76.05
76.06	03957	PRE-BIRTH CENTER		0.000000	0	0	0	0	76.06
76.07	03958	SLEEP LAB		0.000000	0	0	0	0	76.07
76.08	03640	UROLOGY		0.000000	0	0	0	0	76.08
76.09	03959	ADDP OP		0.000000	0	0	0	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL		0.000000	0	0	0	0	76.10
76.11	03960	DIABETES TREATMENT		0.000000	0	0	0	0	76.11
76.12	03961	MENTAL HEALTH CENTER		0.000000	0	0	0	0	76.12
76.13	03650	VEIN CLINIC		0.000000	0	0	0	0	76.13
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	MERCY CLINICS		0.000000	0	0	0	0	90.01
90.02	09002	MERCY CLINIC STATE ST		0.000000	0	0	0	0	90.02
90.03	09003	MERCY CLINIC POLK ST		0.000000	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			20,133	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			20,133	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)			17,764	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)			5,151	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)			34,910,358	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)			34,910,358	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)			34,910,358	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)			1,733.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			8,931,782	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)			8,931,782	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
11/1/2021 6:08 pm

			Title XVIII		Hospital	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,691,452	3,319	2,317.40	1,036	2,400,826	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NURSERY INTENSIVE CARE CENTER	2,598,656	1,264	2,055.90	0	0	44.01
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
46.01	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01
46.02	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.02
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)					10,247,070	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,579,678	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,173,144	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					850,329	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,023,473	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					19,556,205	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)					2,369	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,733.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,107,822	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,841,661	34,910,358	0.110044	4,107,822	452,041
91.00	Nursing School cost	0	34,910,358	0.000000	4,107,822	0
92.00	Allied health cost	0	34,910,358	0.000000	4,107,822	0
93.00	All other Medical Education	0	34,910,358	0.000000	4,107,822	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1
		Component CCN: 14-S158		Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,443	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,443	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)		3,443	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)		406	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)		6,033,805	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)		6,033,805	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)		6,033,805	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)		1,752.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		711,507	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)		711,507	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1	
				Component CCN: 14-S158		Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IPF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		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	0	0	0.00	0	0	44.00
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0	44.01
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
46.01	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01
46.02	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.02
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)					111,437	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					822,944	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)					71,034	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,806	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					76,840	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					746,104	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: 14-0158 Component CCN: 14-S158		Period: From 07/01/2020 To 05/31/2021		Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	602,379	6,033,805	0.099834	0	0	90.00
91.00	Nursing School cost	0	6,033,805	0.000000	0	0	91.00
92.00	Allied health cost	0	6,033,805	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,033,805	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Subprovider - IRF	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)		1,645	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,645	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)		1,645	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)		937	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)		3,191,013	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)		3,191,013	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)		3,191,013	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)		1,939.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,817,621	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)		1,817,621	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158 Component CCN: 14-T158		Period: From 07/01/2020 To 05/31/2021		Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)			
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)					
		1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		0	42.00	
Intensive Care Type Inpatient Hospital Units									
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00	
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	0	44.00	
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0	0	44.01	
45.00	BURN INTENSIVE CARE UNIT							45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	46.00	
46.01	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	46.01	
46.02	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	46.02	
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)						790,757	48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,608,378	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)						169,044	50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						68,759	51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)						237,803	52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,370,575	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: 14-0158 Component CCN: 14-T158		Period: From 07/01/2020 To 05/31/2021		Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII		Subprovider - IRF		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	296,769	3,191,013	0.093002	0	0	90.00
91.00	Nursing School cost	0	3,191,013	0.000000	0	0	91.00
92.00	Allied health cost	0	3,191,013	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,191,013	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm
		Title XIX	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,133	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,133	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)	17,764	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)	724	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)	1,532	15.00	
16.00	Nursery days (title V or XIX only)	500	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)	38,739,404	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)	38,739,404	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)	38,739,404	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)	1,924.17	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,393,099	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)	1,393,099	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
11/1/2021 6:08 pm

			Title XIX		Hospital	Cost		
	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)	792,726	1,532	517.45	500	258,725	42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,948,179	3,319	2,394.75	300	718,425	43.00	
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00	
44.01	NURSERY INTENSIVE CARE CENTER	2,787,675	1,264	2,205.44	500	1,102,720	44.01	
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00	
46.01	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.01	
46.02	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.02	
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)						3,472,969	49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						2,369	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,924.17	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,558,359	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
11/1/2021 6:08 pm

		Title XIX		Hospital		Cost	
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	3,841,661	38,739,404	0.099167	4,558,359	452,039	90.00
91.00	Nursing School cost	0	38,739,404	0.000000	4,558,359	0	91.00
92.00	Allied health cost	0	38,739,404	0.000000	4,558,359	0	92.00
93.00	All other Medical Education	0	38,739,404	0.000000	4,558,359	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,443 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,443 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)			3,443 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)			274 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)			1,532 15.00
16.00	Nursery days (title V or XIX only)			500 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)			6,033,805 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)			6,033,805 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)			6,033,805 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)			1,752.48 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			480,180 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)			480,180 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1
				Component CCN: 14-S158		Date/Time Prepared: 11/1/2021 6:08 pm
				Title XIX	Subprovider - IPF	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT	0	0	0.00	0	0
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
46.01	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
46.02	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					480,180
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-S158		Period: From 07/01/2020 To 05/31/2021		Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XIX		Subprovider - IPF		Cost	
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	602,379	6,033,805	0.099834	0	0	90.00
91.00	Nursing School cost	0	6,033,805	0.000000	0	0	91.00
92.00	Allied health cost	0	6,033,805	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,033,805	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 11/1/2021 6:08 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,645 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,645 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)			1,645 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)			81 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)			1,532 15.00
16.00	Nursery days (title V or XIX only)			500 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)			3,191,013 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)			3,191,013 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)			3,191,013 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)			1,939.83 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			157,126 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)			157,126 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-1
				Component CCN: 14-T158		Date/Time Prepared: 11/1/2021 6:08 pm
				Title XIX	Subprovider - IRF	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT	0	0	0.00	0	0
44.01	NURSERY INTENSIVE CARE CENTER	0	0	0.00	0	0
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
46.01	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
46.02	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					157,126
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0158

Period:

Worksheet D-1

Component CCN: 14-T158

From 07/01/2020
To 05/31/2021Date/Time Prepared:
11/1/2021 6:08 pm

Title XIX

Subprovider -
IRF

Cost

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	296,769	3,191,013	0.093002	0	0	90.00
91.00	Nursing School cost	0	3,191,013	0.000000	0	0	91.00
92.00	Allied health cost	0	3,191,013	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,191,013	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 11/1/2021 6:08 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		13,043,368	30.00
31.00	03100	INTENSIVE CARE UNIT		3,623,234	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
32.01	02060	NURSERY INTENSIVE CARE CENTER		0	32.01
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
34.01	03401	SURGICAL INTENSIVE CARE UNIT		0	34.01
34.02	03402	SURGICAL INTENSIVE CARE UNIT		0	34.02
40.00	04000	SUBPROVIDER - IPF		0	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	0.586579	838,968	50.00
50.01	03340	GI LAB	0.389716	214,885	50.01
51.00	05100	RECOVERY ROOM	0.735598	135,746	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.876914	0	52.00
53.00	05300	ANESTHESIOLOGY	0.187758	155,245	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275030	2,077,025	54.00
54.01	05401	MRI CENTER	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.299274	36,857	55.00
56.00	05600	RADIOISOTOPE	0.210407	261,056	56.00
57.00	05700	CT SCAN	0.055412	3,035,881	57.00
58.00	05800	MRI	0.124690	490,227	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.481006	2,480,135	59.00
60.00	06000	LABORATORY	0.199628	8,940,355	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.326139	1,806,494	65.00
66.00	06600	PHYSICAL THERAPY	0.857844	324,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.699027	222,077	67.00
68.00	06800	SPEECH PATHOLOGY	0.488964	188,930	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.855708	32,719	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.895492	918,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.218126	347,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415518	3,162,268	73.00
74.00	07400	RENAL DIALYSIS	1.057566	286,021	74.00
76.00	03951	EMG	0.000000	0	76.00
76.01	03952	CARDIOVASCULAR LAB	0.000000	0	76.01
76.02	03953	MERCY EYE CENTER	1.467172	0	76.02
76.03	03954	MERCY ENT	0.000000	0	76.03
76.04	03955	WOUND CARE CENTER	0.585554	1,680	76.04
76.05	03956	CARDIAC REHAB	0.000000	0	76.05
76.06	03957	PRE-BIRTH CENTER	0.328891	0	76.06
76.07	03958	SLEEP LAB	0.362500	0	76.07
76.08	03640	UROLOGY	0.571165	0	76.08
76.09	03959	ADDP OP	0.000000	0	76.09
76.10	03550	PSYCH PARTIAL HOSPITAL	0.544464	0	76.10
76.11	03960	DIABETES TREATMENT	3.023003	0	76.11
76.12	03961	MENTAL HEALTH CENTER	1.549477	0	76.12
76.13	03650	VEIN CLINIC	0.000000	0	76.13
76.97	07697	CARDIAC REHABILITATION	1.291992	350	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	MERCY CLINICS	8.289480	0	90.01
90.02	09002	MERCY CLINIC STATE ST	0.000000	0	90.02
90.03	09003	MERCY CLINIC POLK ST	0.000000	0	90.03
91.00	09100	EMERGENCY	0.577614	2,587,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930817	176,160	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,720,737	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)		28,720,737	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
32.01	02060 NURSERY INTENSIVE CARE CENTER		0		32.01
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
34.01	03401 SURGICAL INTENSIVE CARE UNIT		0		34.01
34.02	03402 SURGICAL INTENSIVE CARE UNIT		0		34.02
40.00	04000 SUBPROVIDER - IPF		802,655		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	0.586579	0	0	50.00
50.01	03340 GI LAB	0.389716	0	0	50.01
51.00	05100 RECOVERY ROOM	0.735598	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.876914	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.187758	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.275030	4,700	1,293	54.00
54.01	05401 MRI CENTER	0.000000	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.299274	0	0	55.00
56.00	05600 RADIOISOTOPE	0.210407	0	0	56.00
57.00	05700 CT SCAN	0.055412	19,918	1,104	57.00
58.00	05800 MRI	0.124690	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.481006	11,494	5,529	59.00
60.00	06000 LABORATORY	0.199628	144,912	28,928	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.326139	376	123	65.00
66.00	06600 PHYSICAL THERAPY	0.857844	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.699027	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.488964	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.855708	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.895492	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.218126	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.415518	30,123	12,517	73.00
74.00	07400 RENAL DIALYSIS	1.057566	0	0	74.00
76.00	03951 EMG	0.000000	0	0	76.00
76.01	03952 CARDIOVASCULAR LAB	0.000000	0	0	76.01
76.02	03953 MERCY EYE CENTER	1.467172	0	0	76.02
76.03	03954 MERCY ENT	0.000000	0	0	76.03
76.04	03955 WOUND CARE CENTER	0.585554	0	0	76.04
76.05	03956 CARDIAC REHAB	0.000000	0	0	76.05
76.06	03957 PRE-BIRTH CENTER	0.328891	0	0	76.06
76.07	03958 SLEEP LAB	0.362500	0	0	76.07
76.08	03640 UROLOGY	0.571165	0	0	76.08
76.09	03959 ADDP OP	0.000000	0	0	76.09
76.10	03550 PSYCH PARTIAL HOSPITAL	0.544464	0	0	76.10
76.11	03960 DIABETES TREATMENT	3.023003	0	0	76.11
76.12	03961 MENTAL HEALTH CENTER	1.549477	0	0	76.12
76.13	03650 VEIN CLINIC	0.000000	0	0	76.13
76.97	07697 CARDIAC REHABILITATION	1.291992	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 MERCY CLINICS	8.289480	0	0	90.01
90.02	09002 MERCY CLINIC STATE ST	0.000000	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.577614	107,240	61,943	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.930817	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		318,763	111,437	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)		318,763		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII	Subprovider - IRF	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		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
32.01	02060 NURSERY INTENSIVE CARE CENTER		0		32.01
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
34.01	03401 SURGICAL INTENSIVE CARE UNIT		0		34.01
34.02	03402 SURGICAL INTENSIVE CARE UNIT		0		34.02
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		1,914,909		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.586579	4,615	2,707	50.00
50.01	03340 GI LAB	0.389716	0	0	50.01
51.00	05100 RECOVERY ROOM	0.735598	509	374	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.876914	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.187758	524	98	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.275030	3,372	927	54.00
54.01	05401 MRI CENTER	0.000000	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.299274	0	0	55.00
56.00	05600 RADIOISOTOPE	0.210407	0	0	56.00
57.00	05700 CT SCAN	0.055412	5,941	329	57.00
58.00	05800 MRI	0.124690	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.481006	7,592	3,652	59.00
60.00	06000 LABORATORY	0.199628	228,956	45,706	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.326139	12,977	4,232	65.00
66.00	06600 PHYSICAL THERAPY	0.857844	356,302	305,652	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.699027	369,610	258,367	67.00
68.00	06800 SPEECH PATHOLOGY	0.488964	159,401	77,941	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.855708	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.895492	9,985	8,941	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.218126	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.415518	96,337	40,030	73.00
74.00	07400 RENAL DIALYSIS	1.057566	39,526	41,801	74.00
76.00	03951 EMG	0.000000	0	0	76.00
76.01	03952 CARDIOVASCULAR LAB	0.000000	0	0	76.01
76.02	03953 MERCY EYE CENTER	1.467172	0	0	76.02
76.03	03954 MERCY ENT	0.000000	0	0	76.03
76.04	03955 WOUND CARE CENTER	0.585554	0	0	76.04
76.05	03956 CARDIAC REHAB	0.000000	0	0	76.05
76.06	03957 PRE-BIRTH CENTER	0.328891	0	0	76.06
76.07	03958 SLEEP LAB	0.362500	0	0	76.07
76.08	03640 UROLOGY	0.571165	0	0	76.08
76.09	03959 ADDP OP	0.000000	0	0	76.09
76.10	03550 PSYCH PARTIAL HOSPITAL	0.544464	0	0	76.10
76.11	03960 DIABETES TREATMENT	3.023003	0	0	76.11
76.12	03961 MENTAL HEALTH CENTER	1.549477	0	0	76.12
76.13	03650 VEIN CLINIC	0.000000	0	0	76.13
76.97	07697 CARDIAC REHABILITATION	1.291992	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 MERCY CLINICS	8.289480	0	0	90.01
90.02	09002 MERCY CLINIC STATE ST	0.000000	0	0	90.02
90.03	09003 MERCY CLINIC POLK ST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.577614	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.930817	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,295,647	790,757	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)		1,295,647		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet E Part A Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			3,241,710	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			7,211,225	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)			136,230	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			363,280	2.04
3.00	Managed Care Simulated Payments			7,580,060	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			176.32	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)			95.51	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)			8.50	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)			16.64	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)			103.65	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			80.46	10.00
11.00	FTE count for residents in dental and podiatric programs.			5.01	11.00
12.00	Current year allowable FTE (see instructions)			85.47	12.00
13.00	Total allowable FTE count for the prior year.			106.76	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.			107.40	14.00
15.00	Sum of lines 12 through 14 divided by 3.			99.88	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			99.88	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.566470	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.580533	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.566470	21.00
22.00	IME payment adjustment (see instructions)			2,813,021	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			2,039,893	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)			-23.19	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)			2,813,021	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			2,039,893	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			17.35	30.00
31.00	Percentage of Medicaid patient days (see instructions)			44.37	31.00
32.00	Sum of lines 30 and 31			61.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)			40.13	33.00
34.00	Disproportionate share adjustment (see instructions)			1,048,691	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet E Part A Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,193,466	2,478,468		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	551,363	1,650,048		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,201,411			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	17,015,568			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)		19,055,461		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,277,800		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).		3,199,181		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		164,754		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 intructions)		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)		23,697,196		59.00
60.00	Primary payer payments		15,795		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,681,401		61.00
62.00	Deductibles billed to program beneficiaries		1,005,074		62.00
63.00	Coinsurance billed to program beneficiaries		114,998		63.00
64.00	Allowable bad debts (see instructions)		522,982		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		339,938		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		522,982		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,901,267		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-41,661		70.93
70.94	HRR adjustment amount (see instructions)		-123,631		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet E Part A Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		203,328	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,532,647	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		29,472,535	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-6,939,888	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		481,685	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/1/2021 6:08 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,241,710	3,241,710		3,241,710	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,211,225		7,211,225	7,211,225	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	136,230	136,230		136,230	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	363,280		363,280	363,280	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,580,060	7,580,060	0	7,580,060	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.566470	0.566470	0.566470		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,813,021	872,386	1,940,635	2,813,021	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	2,039,893	2,039,893	0	2,039,893	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	2,813,021	872,386	1,940,635	2,813,021	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	2,039,893	2,039,893	0	2,039,893	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4013	0.4013	0.4013		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,048,691	325,225	723,466	1,048,691	11.00
11.01	Uncompensated care payments	36.00	2,201,411	2,201,411	0	2,201,411	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,015,568	6,776,962	10,238,606	17,015,568	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,055,461	8,816,855	10,238,606	19,055,461	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,277,800	1,875,375	-597,575	1,277,800	16.00
17.00	Special add-on payments for new technologies	54.00	164,754	45,246	119,508	164,754	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,737,476	9,760,539	20,498,015	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/1/2021 6:08 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	773,282	1,142,353	-369,071	773,282	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,220	-1,625	8,845	7,220	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.5100	0.5100	0.5100		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	394,374	582,600	-188,226	394,374	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1331	0.1331	0.1331		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	102,924	152,047	-49,123	102,924	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,277,800	1,875,375	-597,575	1,277,800	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-41,661	24,205	-65,866	-41,661	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-123,631	69,269	-192,900	-123,631	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		108,310	95,018	203,328	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems		MERCY HOSPITAL & MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet E Part B Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			11,366,313	2.00
3.00	OPPS payments			5,753,566	3.00
4.00	Outlier payment (see instructions)			26,259	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5,779,825	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,109,317	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			4,670,508	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			1,454,775	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)			6,125,283	30.00
31.00	Primary payer payments			129	31.00
32.00	Subtotal (line 30 minus line 31)			6,125,154	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)			227,214	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			147,689	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			227,214	36.00
37.00	Subtotal (see instructions)			6,272,843	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			6,272,843	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			6,527,795	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)			-254,952	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: 14-0158 Component CCN: 14-S158	Period: From 07/01/2020 To 05/31/2021	Worksheet E Part B Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		0	2.00
3.00	OPPI payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.850	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	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)		0	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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	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)		0	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		0	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2020 To 05/31/2021	Worksheet E Part B Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.850	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	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)		0	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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	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)		0	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		0	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet E-1
Part I
Date/Time Prepared:
11/1/2021 6:08 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		33,039,057		6,751,076	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	05/26/2021	3,566,522	05/26/2021	223,281	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)		-3,566,522		-223,281	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)		29,472,535		6,527,795	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,939,888		254,952	6.02
7.00	Total Medicare program liability (see instructions)		22,532,647		6,272,843	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: 14-0158
 Component CCN: 14-S158

 Period:
 From 07/01/2020
 To 05/31/2021

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/1/2021 6:08 pm

		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		344,145		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		344,145		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		344,145		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0158

Period:

Worksheet E-1

Component CCN: 14-T158

From 07/01/2020
To 05/31/2021Part I
Date/Time Prepared:
11/1/2021 6:08 pm

		Title XVIII		Subprovider - IRF		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					0	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		1,977,958			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	05/26/2021	11,586			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		11,586			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,989,544			0	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		52,908			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		2,042,452			0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet E-1
Part II
Date/Time Prepared:
11/1/2021 6:08 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2020 To 05/31/2021	Worksheet E-3 Part II Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		383,321	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)		10.277612	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)		383,321	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)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		383,321	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		383,321	18.00
19.00	Deductibles		24,240	19.00
20.00	Subtotal (line 18 minus line 19)		359,081	20.00
21.00	Coinsurance		14,936	21.00
22.00	Subtotal (line 20 minus line 21)		344,145	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		344,145	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
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		344,145	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		344,145	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)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2020 To 05/31/2021	Worksheet E-3 Part III Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		1,845,114	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.1139	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		176,024	3.00
4.00	Outlier Payments		29,248	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		1.23	5.00
5.01	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	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	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	7.00
8.00	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	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		4.910448	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		2,050,386	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		2,050,386	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		2,050,386	19.00
20.00	Deductibles		4,224	20.00
21.00	Subtotal (line 19 minus line 20)		2,046,162	21.00
22.00	Coinsurance		3,710	22.00
23.00	Subtotal (line 21 minus line 22)		2,042,452	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		2,042,452	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		2,042,452	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		1,989,544	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		52,908	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		29,248	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,472,969		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,472,969	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,472,969	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,459,906		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,459,906	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2,459,906	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		1,013,063	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,459,906	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,459,906	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,013,063	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,459,906	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,459,906	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		2,459,906	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,459,906	0	40.00
41.00	Interim payments		2,459,906	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-S158	Period: From 07/01/2020 To 05/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		480,180		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		480,180	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		480,180	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		480,180	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		480,180	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0158 Component CCN: 14-T158	Period: From 07/01/2020 To 05/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		157,126		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		157,126	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		157,126	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		157,126	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		157,126	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0158		Period: From 07/01/2020 To 05/31/2021		Worksheet E-4 Date/Time Prepared: 11/1/2021 6:08 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					97.51	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					9.50	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					-2.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					17.50	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					103.26	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					73.84	6.00
7.00	Enter the lesser of line 5 or line 6					73.84	7.00
		Primary Care		Other		Total	
		1.00		2.00		3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	54.31		18.88		73.19 8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	54.31		18.88		73.19 9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year			5.01		10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			0.00		10.01	
11.00	Total weighted FTE count	54.31		23.89		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	72.80		34.64		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	73.64		33.25		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	66.92		30.59		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00		0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00		0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00		0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00		0.00		16.01	
17.00	Adjusted rolling average FTE count	66.92		30.59		17.00	
18.00	Per resident amount	116,248.37		102,008.08		18.00	
19.00	Approved amount for resident costs	7,779,341		3,120,427		10,899,768 19.00	
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00 20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00 21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00 22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00 23.00	
24.00	Multiply line 22 time line 23					0 24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)					10,899,768 25.00	
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	7,530		2,595		2,163 26.00	
27.00	Total Inpatient Days (see instructions)	27,999		27,999		27,999 27.00	
28.00	Ratio of inpatient days to total inpatient days	0.268938		0.092682		0.077253 28.00	
29.00	Program direct GME amount	2,931,362		1,010,212		842,040 4,783,614 29.00	
29.01	Percent reduction for MA DGME			7.00		7.00 29.01	
30.00	Reduction for direct GME payments for Medicare Advantage			70,715		58,943 129,658 30.00	
31.00	Net Program direct GME amount					4,653,956 31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet E-4 Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Hospital	PPS
				1.00
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		772,401	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		25,011,000	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		15,795	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		24,995,205	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		11,366,313	42.00
43.00	Primary payer payments (see instructions)		129	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		11,366,184	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		36,361,389	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.687411	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.312589	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		4,653,956	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		3,199,181	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,454,775	50.00

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

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet G

Date/Time Prepared:
11/1/2021 6:08 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	7,575,879	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	21,969,462	0	0	0	4.00
5.00 Other receivable	4,312,541	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	1,089,717	0	0	0	7.00
8.00 Prepaid expenses	480,877	0	0	0	8.00
9.00 Other current assets	1,196,449	0	0	0	9.00
10.00 Due from other funds	11,246,299	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	47,871,224	0	0	0	11.00
FIXED ASSETS					
12.00 Land	25,008,000	0	0	0	12.00
13.00 Land improvements	7,313	0	0	0	13.00
14.00 Accumulated depreciation	-7,313	0	0	0	14.00
15.00 Buildings	3,939,762	0	0	0	15.00
16.00 Accumulated depreciation	-3,939,762	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	5,845,507	0	0	0	23.00
24.00 Accumulated depreciation	-5,845,507	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	25,008,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	7,919,688	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	3,227,321	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	11,147,009	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	84,026,233	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	111,618,512	0	0	0	37.00
38.00 Salaries, wages, and fees payable	93,012,255	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	4,761,511	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	24,139,750	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	233,532,028	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	55,384,094	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)	55,384,094	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	288,916,122	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	-204,889,889	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	-204,889,889	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	84,026,233	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet G-1

Date/Time Prepared:
11/1/2021 6:08 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-104,730,644		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-122,840,812				2.00
3.00	Total (sum of line 1 and line 2)		-227,571,456		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)		-227,571,456		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	4,778,510		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)		4,778,510		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-232,349,966		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		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: 14-0158

Period:
From 07/01/2020
To 05/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/1/2021 6:08 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	47,454,435		47,454,435	1.00
2.00	SUBPROVIDER - IPF	6,894,662		6,894,662	2.00
3.00	SUBPROVIDER - IRF	3,325,778		3,325,778	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	57,674,875		57,674,875	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,806,368		11,806,368	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
12.01	NURSERY INTENSIVE CARE CENTER	5,653,100		5,653,100	12.01
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
14.01	SURGICAL INTENSIVE CARE UNIT	0		0	14.01
14.02	SURGICAL INTENSIVE CARE UNIT	0		0	14.02
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	17,459,468		17,459,468	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	75,134,343		75,134,343	17.00
18.00	Ancillary services	114,695,191	193,653,391	308,348,582	18.00
19.00	Outpatient services	0	1,116,570	1,116,570	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS AND OTHER NON HOSPITAL RE	0	57,593,364	57,593,364	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	189,829,534	252,363,325	442,192,859	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		229,057,361		29.00
30.00	NON OPERATING EXPENSES	197,080			30.00
31.00	RE-STRUCTURING EXPENSES	51,957,577			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)		52,154,657		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)		281,212,018		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0158

Period:
From 07/01/2020
To 05/31/2021

Worksheet G-3

Date/Time Prepared:
11/1/2021 6:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	442,192,859	1.00
2.00	Less contractual allowances and discounts on patients' accounts	284,881,153	2.00
3.00	Net patient revenues (line 1 minus line 2)	157,311,706	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	281,212,018	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-123,900,312	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	165,400	6.00
7.00	Income from investments	104,007	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	423,437	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER RENT REVENUE	40,299	24.00
24.01	CAPITATION REVENUE AND MGD CARE DIS	2,161,980	24.01
24.02	GRANTS	1,749,046	24.02
24.03	INTER COMPNAY TRWASURY REVENUE	-1,796,795	24.03
24.04	REFERRAL LAB	76,820	24.04
24.05	CONTRACT REVENUE	0	24.05
24.06	CMS 2% DISCOUNT	0	24.06
24.07	MISCELLANEOUS REVENUE	36,108	24.07
24.50	COVID-19 PHE Funding	-1,900,802	24.50
25.00	Total other income (sum of lines 6-24)	1,059,500	25.00
26.00	Total (line 5 plus line 25)	-122,840,812	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-122,840,812	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0158	Period: From 07/01/2020 To 05/31/2021	Worksheet L Parts I-III Date/Time Prepared: 11/1/2021 6:08 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		773,282	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,220	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)		68.39	3.00
4.00	Number of interns & residents (see instructions)		99.88	4.00
5.00	Indirect medical education percentage (see instructions)		51.00	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)		394,374	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		17.35	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		44.37	8.00
9.00	Sum of lines 7 and 8		61.72	9.00
10.00	Allowable disproportionate share percentage (see instructions)		13.31	10.00
11.00	Disproportionate share adjustment (see instructions)		102,924	11.00
12.00	Total prospective capital payments (see instructions)		1,277,800	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