

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: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet S Parts I-III Date/Time Prepared: 8/14/2021 2:33 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/14/2021	Time: 2:33 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 JACKSON PARK HOSPITAL (14-0177) for the cost reporting period beginning 04/01/2020 and ending 03/31/2021 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	565,091	138,582	0	0	1.00
2.00	Subprovider - IPF	0	59,565	-4		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	624,656	138,578	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: 14-0177		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/14/2021 2:33 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 7531 SOUTH STONEY ISLAND AVENUE			PO Box:				1.00			
2.00	City: CHICAGO			State: IL		Zip Code: 60649		County: COOK			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			JACKSON PARK HOSPITAL	140177	16974	1	07/01/1966	N	P	O
4.00	Subprovider - IPF			JACKSON PARK HOSPITAL	14S177	16974	4	04/01/2019	N	P	O
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2020		03/31/2021		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
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.			583	205	0	6	5,727	0		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

		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	
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.	0	0	0	0	0		25.00
						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.							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.					0		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	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)					N	N	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. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "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		
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		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/14/2021 2:33 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	600,000	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0177		Period: From 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/14/2021 2:33 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/14/2021 2:33 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	10/01/2020 4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/09/2021	Y 07/09/2021 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
8/14/2021 2:33 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.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/14/2021 2:33 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	101	36,865	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)		101	36,865	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		109	39,785	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	74	27,010		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		183			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,282	690	13,172			1.00
2.00	HMO and other (see instructions)	925	5,727				2.00
3.00	HMO IPF Subprovider	0	8,211				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,282	690	13,172			7.00
8.00	INTENSIVE CARE UNIT	563	104	1,989			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	3,845	794	15,161	14.77	486.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,525	932	13,604	0.00	52.46	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			21			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				14.77	539.11	27.00
28.00	Observation Bed Days		61	2,215			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/14/2021 2:33 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	582	127	2,418	1.00
2.00 HMO and other (see instructions)			126	1,065		2.00
3.00 HMO IPF Subprovider				1,805		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	582	127	2,418	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	311	207	3,024	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part II
Date/Time Prepared:
8/14/2021 2:33 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	35,916,737	0	35,916,737	1,121,347.00	32.03
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	763,406	0	763,406	29,533.00	25.85
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,756,676	0	6,756,676	158,566.00	42.61
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,286,768	0	2,286,768	32,442.00	70.49
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,909,808	0	5,909,808		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,034,023	0	1,034,023		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		192,586	0	192,586		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part II
Date/Time Prepared:
8/14/2021 2:33 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	104,067	0	104,067	4,432.00	23.48	26.00
27.00	Administrative & General	5.00	7,805,014	0	7,805,014	173,859.00	44.89	27.00
28.00	Administrative & General under contract (see inst.)		1,202,926	0	1,202,926	13,948.00	86.24	28.00
29.00	Maintenance & Repairs	6.00	607,762	0	607,762	17,070.00	35.60	29.00
30.00	Operation of Plant	7.00	970,081	0	970,081	51,917.00	18.69	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,100,859	0	1,100,859	67,542.00	16.30	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	888,230	-264,076	624,154	36,141.00	17.27	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	264,076	264,076	14,230.00	18.56	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,341,802	0	1,341,802	41,437.00	32.38	38.00
39.00	Central Services and Supply	14.00	66,062	0	66,062	4,281.00	15.43	39.00
40.00	Pharmacy	15.00	711,538	0	711,538	17,492.00	40.68	40.00
41.00	Medical Records & Medical Records Library	16.00	537,285	0	537,285	25,095.00	21.41	41.00
42.00	Social Service	17.00	133,949	0	133,949	6,531.00	20.51	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part III
Date/Time Prepared:
8/14/2021 2:33 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)	36,356,257	0	36,356,257	1,105,762.00	32.88	1.00
2.00	Excluded area salaries (see instructions)	6,756,676	0	6,756,676	158,566.00	42.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,599,581	0	29,599,581	947,196.00	31.25	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,286,768	0	2,286,768	32,442.00	70.49	4.00
5.00	Subtotal wage-related costs (see inst.)	5,909,808	0	5,909,808	0.00	19.97	5.00
6.00	Total (sum of lines 3 thru 5)	37,796,157	0	37,796,157	979,638.00	38.58	6.00
7.00	Total overhead cost (see instructions)	15,469,575	0	15,469,575	473,975.00	32.64	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
8/14/2021 2:33 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	666,372	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	3,031,441	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	148,897	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	731,668	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	2,463,038	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	95,001	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,136,417	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: 14-0177

 Period:
 From 04/01/2020
 To 03/31/2021

 Worksheet S-3
 Part V
 Date/Time Prepared:
 8/14/2021 2:33 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	2,286,768	7,136,417	1.00
2.00	Hospital	2,286,768	7,136,417	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet S-10

Date/Time Prepared:
8/14/2021 2:33 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)		0.281845	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		47,663,364	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		104,152,577	6.00
7.00	Medicaid cost (line 1 times line 6)		29,354,883	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)	6,735,491	138	6,735,629
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,898,364	138	1,898,502
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,898,364	138	1,898,502
			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)		11,686,952	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		596,459	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		917,630	27.01
28.00	Non-Medicare bad debt expense (see instructions)		10,769,322	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,356,451	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,254,953	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,254,953	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/14/2021 2:33 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		0	0	3,800,418	3,800,418	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	104,067	72,001	176,068	7,390,741	7,566,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,805,014	24,970,397	32,775,411	-11,191,159	21,584,252	5.00
6.00	00600	MAINTENANCE & REPAIRS	607,762	254,748	862,510	0	862,510	6.00
7.00	00700	OPERATION OF PLANT	970,081	1,854,970	2,825,051	0	2,825,051	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	251,761	251,761	0	251,761	8.00
9.00	00900	HOUSEKEEPING	1,100,859	310,000	1,410,859	0	1,410,859	9.00
10.00	01000	DIETARY	888,230	651,559	1,539,789	-457,788	1,082,001	10.00
11.00	01100	CAFETERIA	0	-4,675	-4,675	457,788	453,113	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	-2,895	-2,895	0	-2,895	12.00
13.00	01300	NURSING ADMINISTRATION	1,341,802	266,554	1,608,356	0	1,608,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,062	186,077	252,139	-137,240	114,899	14.00
15.00	01500	PHARMACY	711,538	1,323,813	2,035,351	-1,280,763	754,588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537,285	141,238	678,523	0	678,523	16.00
17.00	01700	SOCIAL SERVICE	133,949	0	133,949	0	133,949	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	763,406	135,265	898,671	0	898,671	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	845	845	0	845	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	6,951,314	223,783	7,175,097	-114,459	7,060,638	30.00
31.00	03100	INTENSIVE CARE UNIT	1,170,779	2,019,408	3,190,187	-69,497	3,120,690	31.00
40.00	04000	SUBPROVIDER - IPF	3,450,516	539,255	3,989,771	-4,066	3,985,705	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	795,785	537,782	1,333,567	-325,428	1,008,139	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,048,523	999,487	2,048,010	-3,529	2,044,481	54.00
55.01	03190	CHEMO THERAPY	0	0	0	2,445	2,445	55.01
56.00	05600	RADIOISOTOPE	115,984	119,969	235,953	0	235,953	56.00
57.00	05700	CT SCAN	281,292	122,144	403,436	-20,025	383,411	57.00
60.00	06000	LABORATORY	0	3,638,966	3,638,966	-11,889	3,627,077	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,015,241	312,952	1,328,193	-17,320	1,310,873	65.00
66.00	06600	PHYSICAL THERAPY	379,334	44,595	423,929	-15	423,914	66.00
69.00	06900	ELECTROCARDIOLOGY	244,049	6,446	250,495	-245	250,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	804,314	804,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	102,851	102,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,280,763	1,280,763	73.00
74.00	07400	RENAL DIALYSIS	0	316,802	316,802	0	316,802	74.00
76.00	03550	OP PSYCH	178,551	997	179,548	0	179,548	76.00
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							
91.00	09100	EMERGENCY	1,949,154	3,463,285	5,412,439	-205,897	5,206,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,610,577	42,757,529	75,368,106	0	75,368,106	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,217,187	507,900	3,725,087	0	3,725,087	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	88,973	112,314	201,287	0	201,287	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	35,916,737	43,377,743	79,294,480	0	79,294,480	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-4,427	3,795,991	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-105	7,566,704	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,451,610	14,132,642	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	862,510	6.00
7.00	00700	OPERATION OF PLANT	-126,481	2,698,570	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	251,761	8.00
9.00	00900	HOUSEKEEPING	0	1,410,859	9.00
10.00	01000	DIETARY	0	1,082,001	10.00
11.00	01100	CAFETERIA	-210,120	242,993	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	-2,895	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,608,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	114,899	14.00
15.00	01500	PHARMACY	0	754,588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,610	675,913	16.00
17.00	01700	SOCIAL SERVICE	0	133,949	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	898,671	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	845	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-15,750	7,044,888	30.00
31.00	03100	INTENSIVE CARE UNIT	-205,000	2,915,690	31.00
40.00	04000	SUBPROVIDER - IPF	-383,341	3,602,364	40.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,008,139	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-900,000	1,144,481	54.00
55.01	03190	CHEMO THERAPY	0	2,445	55.01
56.00	05600	RADIOISOTOPE	0	235,953	56.00
57.00	05700	CT SCAN	0	383,411	57.00
60.00	06000	LABORATORY	0	3,627,077	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-22,917	1,287,956	65.00
66.00	06600	PHYSICAL THERAPY	0	423,914	66.00
69.00	06900	ELECTROCARDIOLOGY	0	250,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	804,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	102,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,280,763	73.00
74.00	07400	RENAL DIALYSIS	-228,055	88,747	74.00
76.00	03550	OP PSYCH	0	179,548	76.00
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					
91.00	09100	EMERGENCY	-1,782,819	3,423,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.01	04950	CANCER CENTER	0	0	93.01
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,333,235	64,034,871	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,725,087	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	201,287	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,333,235	67,961,245	200.00

RECLASSIFICATIONS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet A-6
Date/Time Prepared:
8/14/2021 2:33 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPT 950 ALLOCATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,280,558	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	335,364	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,390,741	3.00
	0		0	11,006,663	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	264,076	193,712	1.00
	0		264,076	193,712	
	E - CHG MED SUPP				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	804,314	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	102,851	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	0		0	907,165	
	F - CHARGEABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,280,763	1.00
	0		0	1,280,763	
	G - CHEMO THERAPY				
1.00	CHEMO THERAPY	55.01	217	2,228	1.00
	0		217	2,228	
	H - CAPITAL INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	184,496	1.00
	0		0	184,496	
500.00	Grand Total: Increases		264,293	13,575,027	500.00

RECLASSIFICATIONS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet A-6
Date/Time Prepared:
8/14/2021 2:33 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPT 950 ALLOCATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,280,558	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	335,364	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	7,390,741	0		3.00
	0		0	11,006,663			
	D - CAFETERIA						
1.00	DIETARY	10.00	264,076	193,712	0		1.00
	0		264,076	193,712			
	E - CHG MED SUPP						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	137,240	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	112,014	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	69,497	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	4,066	0		4.00
5.00	OPERATING ROOM	50.00	0	325,428	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,529	0		6.00
7.00	CT SCAN	57.00	0	20,025	0		7.00
8.00	LABORATORY	60.00	0	11,889	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	17,320	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	15	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	245	0		11.00
12.00	EMERGENCY	91.00	0	205,897	0		12.00
	0		0	907,165			
	F - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	1,280,763	0		1.00
	0		0	1,280,763			
	G - CHEMO THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	217	2,228	0		1.00
	0		217	2,228			
	H - CAPITAL INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	184,496	12		1.00
	0		0	184,496			
500.00	Grand Total: Decreases		264,293	13,575,027			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,482,024	0	0	0	0	1.00
2.00	Land Improvements	628,040	20,000	0	20,000	0	2.00
3.00	Buildings and Fixtures	40,314,331	0	0	0	0	3.00
4.00	Building Improvements	20,285,983	178,808	0	178,808	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	35,214,353	358,922	0	358,922	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	98,924,731	557,730	0	557,730	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	98,924,731	557,730	0	557,730	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	2,482,024	0				1.00
2.00	Land Improvements	648,040	0				2.00
3.00	Buildings and Fixtures	40,314,331	0				3.00
4.00	Building Improvements	20,464,791	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	35,573,275	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	99,482,461	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	99,482,461	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part II
Date/Time Prepared:
8/14/2021 2:33 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part III
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,427,161	0	61,427,161	0.633267	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,573,275	0	35,573,275	0.366733	0	2.00
3.00	Total (sum of lines 1-2)	97,000,436	0	97,000,436	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	3,280,558	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,280,558	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	330,937	184,496	0	0	3,795,991	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	330,937	184,496	0	0	3,795,991	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-4,427	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-57,311	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,251	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,294,077			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-210,120	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-126,481	OPERATION OF PLANT	7.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,610	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-15,750	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
36.03	LOCKER & ID REVENUE	B	-105	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.03
36.06	CLERICAL FEES	B	-9	ADMINISTRATIVE & GENERAL	5.00	9	36.06
37.00	DIALYSIS RENT	B	-228,055	RENAL DIALYSIS	74.00	0	37.00
40.00	LOBBYING DUES	A	-15,763	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	MISC REV	B	-111,886	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	PROVIDER TAX EXPENSES	A	-7,257,390	ADMINISTRATIVE & GENERAL	5.00	0	42.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,333,235				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8-2

Date/Time Prepared:
8/14/2021 2:33 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	31.00	AGGREGATE-INTENSIVE CARE UNIT	205,000	205,000	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	383,341	383,341	0	0	0	2.00
3.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	900,000	900,000	0	0	0	3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	22,917	22,917	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	1,782,819	1,782,819	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,294,077	3,294,077	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	205,000		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	383,341		2.00
3.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	900,000		3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	22,917		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,782,819		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,294,077		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,795,991	3,795,991			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,566,704	16,511	0	7,583,215	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,132,642	204,550	0	1,652,676	15,989,868 5.00
6.00	00600	MAINTENANCE & REPAIRS	862,510	39,553	0	128,692	1,030,755 6.00
7.00	00700	OPERATION OF PLANT	2,698,570	880,999	0	205,412	3,784,981 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	251,761	14,462	0	0	266,223 8.00
9.00	00900	HOUSEKEEPING	1,410,859	47,423	0	233,104	1,691,386 9.00
10.00	01000	DIETARY	1,082,001	53,786	0	132,163	1,267,950 10.00
11.00	01100	CAFETERIA	242,993	37,601	0	55,917	336,511 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-2,895	44,108	0	0	41,213 12.00
13.00	01300	NURSING ADMINISTRATION	1,608,356	23,151	0	284,123	1,915,630 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,899	53,677	0	13,988	182,564 14.00
15.00	01500	PHARMACY	754,588	22,030	0	150,666	927,284 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	675,913	54,437	0	113,768	844,118 16.00
17.00	01700	SOCIAL SERVICE	133,949	17,993	0	28,363	180,305 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	898,671	0	0	161,649	1,060,320 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	845	8,400	0	0	9,245 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	7,044,888	553,127	0	1,471,874	9,069,889 30.00
31.00	03100	INTENSIVE CARE UNIT	2,915,690	38,444	0	247,909	3,202,043 31.00
40.00	04000	SUBPROVIDER - IPF	3,602,364	451,786	0	730,636	4,784,786 40.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,008,139	161,189	0	168,505	1,337,833 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,481	118,635	0	222,022	1,485,138 54.00
55.01	03190	CHEMO THERAPY	2,445	0	0	46	2,491 55.01
56.00	05600	RADIOISOTOPE	235,953	20,090	0	24,559	280,602 56.00
57.00	05700	CT SCAN	383,411	8,472	0	59,563	451,446 57.00
60.00	06000	LABORATORY	3,627,077	44,241	0	0	3,671,318 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	1,287,956	34,612	0	214,974	1,537,542 65.00
66.00	06600	PHYSICAL THERAPY	423,914	46,519	0	80,323	550,756 66.00
69.00	06900	ELECTROCARDIOLOGY	250,250	0	0	51,677	301,927 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	804,314	0	0	0	804,314 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,851	0	0	0	102,851 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,280,763	0	0	0	1,280,763 73.00
74.00	07400	RENAL DIALYSIS	88,747	116,225	0	0	204,972 74.00
76.00	03550	OP PSYCH	179,548	26,164	0	37,808	243,520 76.00
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							
91.00	09100	EMERGENCY	3,423,723	72,658	0	412,728	3,909,109 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
93.01	04950	CANCER CENTER	0	0	0	0	0 93.01
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,034,871	3,210,843	0	6,883,145	62,749,653 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,725,087	585,148	0	681,230	4,991,465 192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	201,287	0	0	18,840	220,127 194.00
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)	67,961,245	3,795,991	0	7,583,215	67,961,245 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 04/01/2020
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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	15,989,868					5.00
6.00	00600	MAINTENANCE & REPAIRS	317,129	1,347,884				6.00
7.00	00700	OPERATION OF PLANT	1,164,514	335,889	5,285,384			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,908	5,514	28,796	382,441		8.00
9.00	00900	HOUSEKEEPING	520,384	18,080	94,428	0	2,324,278	9.00
10.00	01000	DIETARY	390,106	20,506	107,098	0	48,221	10.00
11.00	01100	CAFETERIA	103,533	14,335	74,870	0	33,711	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12,680	16,817	87,829	0	39,545	12.00
13.00	01300	NURSING ADMINISTRATION	589,376	8,826	46,098	0	20,756	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,169	20,465	106,882	0	48,124	14.00
15.00	01500	PHARMACY	285,295	8,399	43,866	0	19,751	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,707	20,754	108,394	0	48,805	16.00
17.00	01700	SOCIAL SERVICE	55,474	6,860	35,827	0	16,131	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	326,225	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,844	3,203	16,726	0	7,531	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	2,790,497	210,883	1,101,385	175,263	495,902	30.00
31.00	03100	INTENSIVE CARE UNIT	985,163	14,657	76,550	26,427	34,467	31.00
40.00	04000	SUBPROVIDER - IPF	1,472,121	172,246	899,595	180,751	405,045	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	411,607	61,454	320,958	0	144,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,928	45,230	236,225	0	106,361	54.00
55.01	03190	CHEMO THERAPY	766	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	86,332	7,659	40,003	0	18,011	56.00
57.00	05700	CT SCAN	138,895	3,230	16,870	0	7,596	57.00
60.00	06000	LABORATORY	1,129,543	16,867	88,093	0	39,664	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	473,051	13,196	68,919	0	31,031	65.00
66.00	06600	PHYSICAL THERAPY	169,449	17,736	92,628	0	41,706	66.00
69.00	06900	ELECTROCARDIOLOGY	92,893	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	247,461	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,644	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,049	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	63,063	44,311	231,426	0	104,200	74.00
76.00	03550	OP PSYCH	74,923	9,975	52,097	0	23,457	76.00
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								
91.00	09100	EMERGENCY	1,202,704	27,701	144,677	0	65,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,386,433	1,124,793	4,120,240	382,441	1,799,668	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,535,709	223,091	1,165,144	0	524,610	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	67,726	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,989,868	1,347,884	5,285,384	382,441	2,324,278	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	1,833,881					10.00
11.00	01100	CAFETERIA	0	562,960				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	198,084			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	46,066	2,626,752		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,375	0	0	417,579	14.00
15.00	01500	PHARMACY	0	13,778	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,758	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,144	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	23,263	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	840,423	202,278	152,018	1,380,459	0	30.00
31.00	03100	INTENSIVE CARE UNIT	126,723	25,721	0	175,534	0	31.00
40.00	04000	SUBPROVIDER - IPF	866,735	85,944	0	586,530	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,776	0	114,489	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,344	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOTISOTOPE	0	1,671	0	0	0	56.00
57.00	05700	CT SCAN	0	7,339	0	0	0	57.00
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	23,722	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,012	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,522	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	327,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	86,551	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	03550	OP PSYCH	0	5,177	0	0	0	76.00
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								
91.00	09100	EMERGENCY	0	54,178	0	369,740	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,833,881	524,002	198,084	2,626,752	413,726	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34,289	0	0	3,853	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	4,669	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,833,881	562,960	198,084	2,626,752	417,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,298,373					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,301,536				16.00
17.00	01700	SOCIAL SERVICE	0	0	299,741			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	20,435	596,462	137,364	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,339	89,937	20,712	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,018	615,137	141,665	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,199	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26	0	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
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	145	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,209,642	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	0	76.00
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								
91.00	09100	EMERGENCY	334	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,246,138	1,301,536	299,741	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,235	0	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,298,373	1,301,536	299,741	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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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	
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	1,409,808					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		39,549				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,132,440	31,768	0	18,337,466	-1,164,208	30.00
31.00	03100	INTENSIVE CARE UNIT	47,823	1,342	0	4,832,438	-49,165	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	10,219,573	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	96,920	2,719	0	2,508,467	-99,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,302	430	0	2,370,984	-15,732	54.00
55.01	03190	CHEMO THERAPY	0	0	0	3,257	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	434,278	0	56.00
57.00	05700	CT SCAN	0	0	0	625,376	0	57.00
60.00	06000	LABORATORY	0	0	0	4,945,485	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	68,226	1,913	0	2,217,745	-70,139	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	878,287	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	399,342	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,378,950	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	221,046	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,884,454	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	647,972	0	74.00
76.00	03550	OP PSYCH	0	0	0	409,149	0	76.00
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								
91.00	09100	EMERGENCY	49,097	1,377	0	5,824,058	-50,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,409,808	39,549	0	59,138,327	-1,449,357	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	8,530,396	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	292,522	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,409,808	39,549	0	67,961,245	-1,449,357	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
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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
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.01	03190	CHEMO THERAPY	55.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
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	03550	OP PSYCH	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.01	04950	CANCER CENTER	93.01
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet B
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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	16,511	0	16,511	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	109,088	204,550	0	313,638	5.00
6.00	00600	MAINTENANCE & REPAIRS	4,362	39,553	0	43,915	6.00
7.00	00700	OPERATION OF PLANT	0	880,999	0	880,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,462	0	14,462	8.00
9.00	00900	HOUSEKEEPING	0	47,423	0	47,423	9.00
10.00	01000	DIETARY	0	53,786	0	53,786	10.00
11.00	01100	CAFETERIA	0	37,601	0	37,601	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	44,108	0	44,108	12.00
13.00	01300	NURSING ADMINISTRATION	0	23,151	0	23,151	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	720	53,677	0	54,397	14.00
15.00	01500	PHARMACY	0	22,030	0	22,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,910	54,437	0	70,347	16.00
17.00	01700	SOCIAL SERVICE	0	17,993	0	17,993	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	352	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	8,400	0	8,400	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	14,977	553,127	0	568,104	30.00
31.00	03100	INTENSIVE CARE UNIT	6,955	38,444	0	45,399	31.00
40.00	04000	SUBPROVIDER - IPF	0	451,786	0	451,786	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,892	161,189	0	165,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,846	118,635	0	120,481	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	20,090	0	20,090	56.00
57.00	05700	CT SCAN	0	8,472	0	8,472	57.00
60.00	06000	LABORATORY	0	44,241	0	44,241	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	36,078	34,612	0	70,690	65.00
66.00	06600	PHYSICAL THERAPY	0	46,519	0	46,519	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	116,225	0	116,225	74.00
76.00	03550	OP PSYCH	0	26,164	0	26,164	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	285	72,658	0	72,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,113	3,210,843	0	3,404,956	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	585,148	0	585,148	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	15,918	0	0	15,918	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	210,031	3,795,991	0	4,006,022	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

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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	317,237					5.00
6.00	00600	MAINTENANCE & REPAIRS	6,292	50,487				6.00
7.00	00700	OPERATION OF PLANT	23,104	12,579	917,129			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,625	207	4,997	21,291		8.00
9.00	00900	HOUSEKEEPING	10,324	677	16,385	0	75,316	9.00
10.00	01000	DIETARY	7,740	768	18,584	0	1,563	10.00
11.00	01100	CAFETERIA	2,054	537	12,992	0	1,092	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	252	630	15,240	0	1,281	12.00
13.00	01300	NURSING ADMINISTRATION	11,693	331	7,999	0	673	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,114	767	18,546	0	1,559	14.00
15.00	01500	PHARMACY	5,660	315	7,612	0	640	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,152	777	18,809	0	1,581	16.00
17.00	01700	SOCIAL SERVICE	1,101	257	6,217	0	523	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	6,472	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	56	120	2,902	0	244	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	55,366	7,899	191,114	9,757	16,069	30.00
31.00	03100	INTENSIVE CARE UNIT	19,545	549	13,283	1,471	1,117	31.00
40.00	04000	SUBPROVIDER - IPF	29,206	6,452	156,099	10,063	13,125	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,166	2,302	55,693	0	4,683	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,065	1,694	40,990	0	3,447	54.00
55.01	03190	CHEMO THERAPY	15	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	1,713	287	6,941	0	584	56.00
57.00	05700	CT SCAN	2,756	121	2,927	0	246	57.00
60.00	06000	LABORATORY	22,410	632	15,286	0	1,285	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	9,385	494	11,959	0	1,006	65.00
66.00	06600	PHYSICAL THERAPY	3,362	664	16,073	0	1,351	66.00
69.00	06900	ELECTROCARDIOLOGY	1,843	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,910	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	628	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,818	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,251	1,660	40,157	0	3,377	74.00
76.00	03550	OP PSYCH	1,486	374	9,040	0	760	76.00
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								
91.00	09100	EMERGENCY	23,861	1,038	25,105	0	2,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	285,425	42,131	714,950	21,291	58,317	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,468	8,356	202,179	0	16,999	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	1,344	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	317,237	50,487	917,129	21,291	75,316	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
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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	82,729					10.00
11.00	01100	CAFETERIA	0	54,398				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	60,625			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	14,099	58,565		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	326	0	0	76,739	14.00
15.00	01500	PHARMACY	0	1,331	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,909	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	497	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	2,248	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,913	19,548	46,526	30,777	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,717	2,485	0	3,914	0	31.00
40.00	04000	SUBPROVIDER - IPF	39,099	8,305	0	13,077	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,621	0	2,553	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,449	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOTISOTOPE	0	161	0	0	0	56.00
57.00	05700	CT SCAN	0	709	0	0	0	57.00
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	2,292	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	581	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	437	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	60,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,906	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	03550	OP PSYCH	0	500	0	0	0	76.00
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								
91.00	09100	EMERGENCY	0	5,235	0	8,244	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,729	50,634	60,625	58,565	76,031	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,313	0	0	708	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	451	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	886	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	82,729	54,398	61,511	58,565	76,739	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

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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	37,916					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	98,823				16.00
17.00	01700	SOCIAL SERVICE	0	0	26,650			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	597	45,288	12,213			30.00
31.00	03100	INTENSIVE CARE UNIT	156	6,829	1,842			31.00
40.00	04000	SUBPROVIDER - IPF	263	46,706	12,595			40.00
43.00	04300	NURSERY	0	0	0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35	0	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1	0	0			54.00
55.01	03190	CHEMO THERAPY	0	0	0			55.01
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
60.00	06000	LABORATORY	0	0	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	4	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,325	0	0			73.00
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03550	OP PSYCH	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0			93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,391	98,823	26,650	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,525	0	0			192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,916	98,823	26,650	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	9,072					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		11,722				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,044,375	0	30.00
31.00	03100	INTENSIVE CARE UNIT				102,847	0	31.00
40.00	04000	SUBPROVIDER - IPF				788,367	0	40.00
43.00	04300	NURSERY				0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				240,501	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				178,610	0	54.00
55.01	03190	CHEMO THERAPY				15	0	55.01
56.00	05600	RADIOISOTOPE				29,829	0	56.00
57.00	05700	CT SCAN				15,361	0	57.00
60.00	06000	LABORATORY				83,854	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				96,298	0	65.00
66.00	06600	PHYSICAL THERAPY				68,725	0	66.00
69.00	06900	ELECTROCARDIOLOGY				2,393	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				65,035	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				16,534	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				43,143	0	73.00
74.00	07400	RENAL DIALYSIS				162,670	0	74.00
76.00	03550	OP PSYCH				38,406	0	76.00
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								
91.00	09100	EMERGENCY				139,446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.01	04950	CANCER CENTER				0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	3,116,409	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				850,179	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER				17,754	0	194.00
200.00		Cross Foot Adjustments	9,072	11,722	0	20,794	0	200.00
201.00		Negative Cost Centers	0	0	0	886	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,072	11,722	0	4,006,022	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0177

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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
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.01	03190	CHEMO THERAPY	55.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
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
69.00	06900	ELECTROCARDIOLOGY	69.00
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	03550	OP PSYCH	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.01	04950	CANCER CENTER	93.01
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

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Date/Time Prepared:
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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	314,981					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,370	0	35,812,670			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,973	0	7,805,014	-15,989,868	51,971,377	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,282	0	607,762	0	1,030,755	6.00
7.00	00700	OPERATION OF PLANT	73,103	0	970,081	0	3,784,981	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,200	0	0	0	266,223	8.00
9.00	00900	HOUSEKEEPING	3,935	0	1,100,859	0	1,691,386	9.00
10.00	01000	DIETARY	4,463	0	624,154	0	1,267,950	10.00
11.00	01100	CAFETERIA	3,120	0	264,076	0	336,511	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	3,660	0	0	0	41,213	12.00
13.00	01300	NURSING ADMINISTRATION	1,921	0	1,341,802	0	1,915,630	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,454	0	66,062	0	182,564	14.00
15.00	01500	PHARMACY	1,828	0	711,538	0	927,284	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,517	0	537,285	0	844,118	16.00
17.00	01700	SOCIAL SERVICE	1,493	0	133,949	0	180,305	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	763,406	0	1,060,320	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	697	0	0	0	9,245	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	45,897	0	6,951,097	0	9,069,889	30.00
31.00	03100	INTENSIVE CARE UNIT	3,190	0	1,170,779	0	3,202,043	31.00
40.00	04000	SUBPROVIDER - IPF	37,488	0	3,450,516	0	4,784,786	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,375	0	795,785	0	1,337,833	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,844	0	1,048,523	0	1,485,138	54.00
55.01	03190	CHEMO THERAPY	0	0	217	0	2,491	55.01
56.00	05600	RADIOISOTOPE	1,667	0	115,984	0	280,602	56.00
57.00	05700	CT SCAN	703	0	281,292	0	451,446	57.00
60.00	06000	LABORATORY	3,671	0	0	0	3,671,318	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,872	0	1,015,241	0	1,537,542	65.00
66.00	06600	PHYSICAL THERAPY	3,860	0	379,334	0	550,756	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	244,049	0	301,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	804,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	102,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,280,763	73.00
74.00	07400	RENAL DIALYSIS	9,644	0	0	0	204,972	74.00
76.00	03550	OP PSYCH	2,171	0	178,551	0	243,520	76.00
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								
91.00	09100	EMERGENCY	6,029	0	1,949,154	0	3,909,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	266,427	0	32,506,510	-15,989,868	46,759,785	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,554	0	3,217,187	0	4,991,465	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	88,973	0	220,127	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,795,991	0	7,583,215		15,989,868	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.051492	0.000000	0.211747		0.307667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			16,511		317,237	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000461		0.006104	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: 14-0177

Period:
From 04/01/2020
To 03/31/2021

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Date/Time Prepared:
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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	
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	293,356					6.00
7.00	00700	OPERATION OF PLANT	73,103	220,253				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,200	1,200	28,784			8.00
9.00	00900	HOUSEKEEPING	3,935	3,935	0	215,118		9.00
10.00	01000	DIETARY	4,463	4,463	0	4,463	86,352	10.00
11.00	01100	CAFETERIA	3,120	3,120	0	3,120	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	3,660	3,660	0	3,660	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,921	1,921	0	1,921	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,454	4,454	0	4,454	0	14.00
15.00	01500	PHARMACY	1,828	1,828	0	1,828	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,517	4,517	0	4,517	0	16.00
17.00	01700	SOCIAL SERVICE	1,493	1,493	0	1,493	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	697	697	0	697	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	45,897	45,897	13,191	45,897	39,573	30.00
31.00	03100	INTENSIVE CARE UNIT	3,190	3,190	1,989	3,190	5,967	31.00
40.00	04000	SUBPROVIDER - IPF	37,488	37,488	13,604	37,488	40,812	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,375	13,375	0	13,375	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,844	9,844	0	9,844	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	1,667	1,667	0	1,667	0	56.00
57.00	05700	CT SCAN	703	703	0	703	0	57.00
60.00	06000	LABORATORY	3,671	3,671	0	3,671	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,872	2,872	0	2,872	0	65.00
66.00	06600	PHYSICAL THERAPY	3,860	3,860	0	3,860	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,644	9,644	0	9,644	0	74.00
76.00	03550	OP PSYCH	2,171	2,171	0	2,171	0	76.00
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								
91.00	09100	EMERGENCY	6,029	6,029	0	6,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	244,802	171,699	28,784	166,564	86,352	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,554	48,554	0	48,554	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,347,884	5,285,384	382,441	2,324,278	1,833,881	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.594704	23.996876	13.286583	10.804665	21.237273	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,487	917,129	21,291	75,316	82,729	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.172101	4.163980	0.739682	0.350115	0.958044	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: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			CAFETERIA (FTES SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTES SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	34,363					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	43				12.00
13.00	01300	NURSING ADMINISTRATION	0	10	23,494			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	206	0	0	917,990		14.00
15.00	01500	PHARMACY	841	0	0	0	1,374,711	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,206	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	314	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	1,420	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,347	33	12,347	0	21,636	30.00
31.00	03100	INTENSIVE CARE UNIT	1,570	0	1,570	0	5,653	31.00
40.00	04000	SUBPROVIDER - IPF	5,246	0	5,246	0	9,548	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,024	0	1,024	0	1,270	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,547	0	0	0	27	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	102	0	0	0	0	56.00
57.00	05700	CT SCAN	448	0	0	0	0	57.00
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	1,448	0	0	0	154	65.00
66.00	06600	PHYSICAL THERAPY	367	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	276	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	719,248	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	190,271	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,280,763	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	316	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,307	0	3,307	0	354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,985	43	23,494	909,519	1,319,405	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,093	0	0	8,471	55,306	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	285	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	562,960	198,084	2,626,752	417,579	1,298,373	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.382737	4,606.604651	111.805227	0.454884	0.944470	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,398	61,511	58,565	76,739	37,916	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.583040	1,409.883721	2.492764	0.083595	0.027581	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: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	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	28,784					16.00
17.00	01700	SOCIAL SERVICE	0	28,784				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			651,447	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	13,191	13,191	0	0	523,280	30.00
31.00	03100	INTENSIVE CARE UNIT	1,989	1,989	0	0	22,098	31.00
40.00	04000	SUBPROVIDER - IPF	13,604	13,604	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	44,785	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	7,071	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
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	31,526	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	0	76.00
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								
91.00	09100	EMERGENCY	0	0	0	0	22,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,784	28,784	0	0	651,447	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,301,536	299,741	0	0	1,409,808	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.217343	10.413459	0.000000	0.000000	2.164118	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,823	26,650	0	0	9,072	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.433262	0.925862	0.000000	0.000000	0.013926	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: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet B-1
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			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	27,138		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	21,798	0	30.00
31.00	03100	INTENSIVE CARE UNIT	921	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,866	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	295	0	54.00
55.01	03190	CHEMO THERAPY	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,313	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	OP PSYCH	0	0	76.00
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					
91.00	09100	EMERGENCY	945	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.01	04950	CANCER CENTER	0	0	93.01
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,138	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NON REIMBURSEABLE COST CENTER	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	39,549	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.457329	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,722	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.431940	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: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
						RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,173,258		17,173,258	0	17,173,258	30.00
31.00	03100	INTENSIVE CARE UNIT	4,783,273		4,783,273	0	4,783,273	31.00
40.00	04000	SUBPROVIDER - IPF	10,219,573		10,219,573	0	10,219,573	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,408,828		2,408,828	0	2,408,828	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,355,252		2,355,252	0	2,355,252	54.00
55.01	03190	CHEMO THERAPY	3,257		3,257	0	3,257	55.01
56.00	05600	RADIOISOTOPE	434,278		434,278	0	434,278	56.00
57.00	05700	CT SCAN	625,376		625,376	0	625,376	57.00
60.00	06000	LABORATORY	4,945,485		4,945,485	0	4,945,485	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,147,606	0	2,147,606	0	2,147,606	65.00
66.00	06600	PHYSICAL THERAPY	878,287	0	878,287	0	878,287	66.00
69.00	06900	ELECTROCARDIOLOGY	399,342		399,342	0	399,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378,950		1,378,950	0	1,378,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	221,046		221,046	0	221,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,884,454		2,884,454	0	2,884,454	73.00
74.00	07400	RENAL DIALYSIS	647,972		647,972	0	647,972	74.00
76.00	03550	OP PSYCH	409,149		409,149	0	409,149	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,773,584		5,773,584	0	5,773,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,472,139		2,472,139	0	2,472,139	92.00
93.01	04950	CANCER CENTER	0		0	0	0	93.01
200.00		Subtotal (see instructions)	60,161,109	0	60,161,109	0	60,161,109	200.00
201.00		Less Observation Beds	2,472,139		2,472,139	0	2,472,139	201.00
202.00		Total (see instructions)	57,688,970	0	57,688,970	0	57,688,970	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/14/2021 2:33 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	24,348,122		24,348,122			30.00	
31.00	03100	INTENSIVE CARE UNIT	16,814,206		16,814,206			31.00	
40.00	04000	SUBPROVIDER - IPF	17,007,907		17,007,907			40.00	
43.00	04300	NURSERY	0		0			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,879,433	2,805,940	5,685,373	0.423689	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,880,419	5,503,021	10,383,440	0.226828	0.000000	54.00	
55.01	03190	CHEMO THERAPY	71,861	158,064	229,925	0.014165	0.000000	55.01	
56.00	05600	RADIOISOTOPE	712,211	195,867	908,078	0.478239	0.000000	56.00	
57.00	05700	CT SCAN	4,647,721	12,165,293	16,813,014	0.037196	0.000000	57.00	
60.00	06000	LABORATORY	21,693,387	21,050,677	42,744,064	0.115700	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	17,312,503	1,040,468	18,352,971	0.117017	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	554,042	734,652	1,288,694	0.0681533	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	1,861,829	1,433,720	3,295,549	0.121176	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	454,415	369,145	823,560	1.674377	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,982	80,600	201,582	1.096556	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	14,233,300	2,260,131	16,493,431	0.174885	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	4,626,884	202,772	4,829,656	0.134165	0.000000	74.00	
76.00	03550	OP PSYCH	0	442,019	442,019	0.925637	0.000000	76.00	
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								
91.00	09100	EMERGENCY	8,136,860	6,894,036	15,030,896	0.384114	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	992,928	7,997,632	8,990,560	0.274971	0.000000	92.00	
93.01	04950	CANCER CENTER	0	0	0	0.000000	0.000000	93.01	
200.00		Subtotal (see instructions)	141,349,010	63,334,037	204,683,047			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	141,349,010	63,334,037	204,683,047			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.423689			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226828			54.00
55.01	03190	CHEMO THERAPY	0.014165			55.01
56.00	05600	RADIOISOTOPE	0.478239			56.00
57.00	05700	CT SCAN	0.037196			57.00
60.00	06000	LABORATORY	0.115700			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.117017			65.00
66.00	06600	PHYSICAL THERAPY	0.681533			66.00
69.00	06900	ELECTROCARDIOLOGY	0.121176			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.096556			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174885			73.00
74.00	07400	RENAL DIALYSIS	0.134165			74.00
76.00	03550	OP PSYCH	0.925637			76.00
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						
91.00	09100	EMERGENCY	0.384114			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.274971			92.00
93.01	04950	CANCER CENTER	0.000000			93.01
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

Worksheet C
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/14/2021 2:33 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	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,348,122		24,348,122		30.00
31.00	03100	INTENSIVE CARE UNIT	16,814,206		16,814,206		31.00
40.00	04000	SUBPROVIDER - IPF	17,007,907		17,007,907		40.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,879,433	2,805,940	5,685,373	0.423689	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,880,419	5,503,021	10,383,440	0.226828	54.00
55.01	03190	CHEMO THERAPY	71,861	158,064	229,925	0.014165	55.01
56.00	05600	RADIOISOTOPE	712,211	195,867	908,078	0.478239	56.00
57.00	05700	CT SCAN	4,647,721	12,165,293	16,813,014	0.037196	57.00
60.00	06000	LABORATORY	21,693,387	21,050,677	42,744,064	0.115700	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	17,312,503	1,040,468	18,352,971	0.117017	65.00
66.00	06600	PHYSICAL THERAPY	554,042	734,652	1,288,694	0.681533	66.00
69.00	06900	ELECTROCARDIOLOGY	1,861,829	1,433,720	3,295,549	0.121176	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	454,415	369,145	823,560	1.674377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	120,982	80,600	201,582	1.096556	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,233,300	2,260,131	16,493,431	0.174885	73.00
74.00	07400	RENAL DIALYSIS	4,626,884	202,772	4,829,656	0.134165	74.00
76.00	03550	OP PSYCH	0	442,019	442,019	0.925637	76.00
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							
91.00	09100	EMERGENCY	8,136,860	6,894,036	15,030,896	0.384114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	992,928	7,997,632	8,990,560	0.274971	92.00
93.01	04950	CANCER CENTER	0	0	0	0.000000	93.01
200.00		Subtotal (see instructions)	141,349,010	63,334,037	204,683,047		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	141,349,010	63,334,037	204,683,047		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/14/2021 2:33 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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.01	03190	CHEMO THERAPY	0.000000			55.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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	03550	OP PSYCH	0.000000			76.00
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						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.01	04950	CANCER CENTER	0.000000			93.01
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: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part I
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,044,375	0	1,044,375	15,387	67.87	30.00
31.00	INTENSIVE CARE UNIT		102,847		102,847	1,989	51.71	31.00
40.00	SUBPROVIDER - IPF		788,367	0	788,367	13,604	57.95	40.00
43.00	NURSERY		0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)		1,935,589		1,935,589	30,980		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		3,282	222,749				
31.00	INTENSIVE CARE UNIT		563	29,113				
40.00	SUBPROVIDER - IPF		1,525	88,374				
43.00	NURSERY		0	0				
200.00	Total (lines 30 through 199)		5,370	340,236				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part II
Date/Time Prepared:
8/14/2021 2:33 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	240,501	5,685,373	0.042302	719,907	30,454
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,610	10,383,440	0.017201	1,463,765	25,178
55.01	03190	CHEMO THERAPY	15	229,925	0.000065	19,376	1
56.00	05600	RADIOISOTOPE	29,829	908,078	0.032848	193,019	6,340
57.00	05700	CT SCAN	15,361	16,813,014	0.000914	1,831,931	1,674
60.00	06000	LABORATORY	83,854	42,744,064	0.001962	6,123,366	12,014
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	96,298	18,352,971	0.005247	4,759,163	24,971
66.00	06600	PHYSICAL THERAPY	68,725	1,288,694	0.053329	153,063	8,163
69.00	06900	ELECTROCARDIOLOGY	2,393	3,295,549	0.000726	486,223	353
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,035	823,560	0.078968	82,800	6,539
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,534	201,582	0.082021	33,397	2,739
73.00	07300	DRUGS CHARGED TO PATIENTS	43,143	16,493,431	0.002616	3,121,183	8,165
74.00	07400	RENAL DIALYSIS	162,670	4,829,656	0.033681	1,571,481	52,929
76.00	03550	OP PSYCH	38,406	442,019	0.086888	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	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							
91.00	09100	EMERGENCY	139,446	15,030,896	0.009277	1,018,070	9,445
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	150,341	8,990,560	0.016722	274,536	4,591
93.01	04950	CANCER CENTER	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	1,331,161	146,512,812		21,851,280	193,556

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0177		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part III Date/Time Prepared: 8/14/2021 2:33 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	15,387	0.00	3,282	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	1,989	0.00	563	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	13,604	0.00	1,525	40.00		
43.00	04300	NURSERY	0	0	0	0.00	0	43.00		
200.00		Total (lines 30 through 199)	0	0	30,980		5,370	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
40.00	04000	SUBPROVIDER - IPF	0							40.00
43.00	04300	NURSERY	0							43.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0	0	93.01
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/14/2021 2:33 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,685,373	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,383,440	0.000000	54.00
55.01	03190	CHEMO THERAPY	0	0	0	229,925	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	908,078	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	16,813,014	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	42,744,064	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	18,352,971	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,288,694	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,295,549	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	823,560	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	201,582	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,493,431	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,829,656	0.000000	74.00
76.00	03550	OP PSYCH	0	0	0	442,019	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	15,030,896	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,990,560	0.000000	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0.000000	93.01
200.00		Total (lines 50 through 199)	0	0	0	146,512,812		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/14/2021 2:33 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	719,907	0	336,597	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,463,765	0	436,571	0
55.01	03190	CHEMO THERAPY	0.000000	19,376	0	47,300	0
56.00	05600	RADIOISOTOPE	0.000000	193,019	0	36,476	0
57.00	05700	CT SCAN	0.000000	1,831,931	0	828,472	0
60.00	06000	LABORATORY	0.000000	6,123,366	0	996,169	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	4,759,163	0	259,899	0
66.00	06600	PHYSICAL THERAPY	0.000000	153,063	0	269	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	486,223	0	193,346	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	82,800	0	37,178	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	33,397	0	18,960	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,121,183	0	376,572	0
74.00	07400	RENAL DIALYSIS	0.000000	1,571,481	0	23,042	0
76.00	03550	OP PSYCH	0.000000	0	0	72,264	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	1,018,070	0	624,863	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	274,536	0	536,712	0
93.01	04950	CANCER CENTER	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		21,851,280	0	4,824,690	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0177		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part V Date/Time Prepared: 8/14/2021 2:33 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	0.423689	336,597	0	0	142,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226828	436,571	0	0	99,027	54.00
55.01	03190	CHEMO THERAPY	0.014165	47,300	0	0	670	55.01
56.00	05600	RADIOISOTOPE	0.478239	36,476	0	0	17,444	56.00
57.00	05700	CT SCAN	0.037196	828,472	0	0	30,816	57.00
60.00	06000	LABORATORY	0.115700	996,169	1,250	0	115,257	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117017	259,899	0	0	30,413	65.00
66.00	06600	PHYSICAL THERAPY	0.681533	269	0	0	183	66.00
69.00	06900	ELECTROCARDIOLOGY	0.121176	193,346	0	0	23,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377	37,178	0	0	62,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.096556	18,960	0	0	20,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174885	376,572	0	0	65,857	73.00
74.00	07400	RENAL DIALYSIS	0.134165	23,042	0	0	3,091	74.00
76.00	03550	OP PSYCH	0.925637	72,264	0	0	66,890	76.00
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								
91.00	09100	EMERGENCY	0.384114	624,863	0	0	240,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.274971	536,712	0	0	147,580	92.00
93.01	04950	CANCER CENTER	0.000000	0	0	0	0	93.01
200.00		Subtotal (see instructions)		4,824,690	1,250	0	1,066,329	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,824,690	1,250	0	1,066,329	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/14/2021 2:33 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.01	03190	CHEMO THERAPY	0	0		55.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	145	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	OP PSYCH	0	0		76.00
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					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.01	04950	CANCER CENTER	0	0		93.01
200.00		Subtotal (see instructions)	145	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	145	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0177

Period:

Worksheet D

Component CCN: 14-S177

From 04/01/2020
To 03/31/2021Part II
Date/Time Prepared:
8/14/2021 2:33 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	240,501	5,685,373	0.042302	2,308	98	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,610	10,383,440	0.017201	13,234	228	54.00
55.01	03190	CHEMO THERAPY	15	229,925	0.000065	0	0	55.01
56.00	05600	RADIOISOTOPE	29,829	908,078	0.032848	0	0	56.00
57.00	05700	CT SCAN	15,361	16,813,014	0.000914	28,698	26	57.00
60.00	06000	LABORATORY	83,854	42,744,064	0.001962	358,495	703	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	96,298	18,352,971	0.005247	36,978	194	65.00
66.00	06600	PHYSICAL THERAPY	68,725	1,288,694	0.053329	1,245	66	66.00
69.00	06900	ELECTROCARDIOLOGY	2,393	3,295,549	0.000726	7,457	5	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,035	823,560	0.078968	514	41	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,534	201,582	0.082021	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,143	16,493,431	0.002616	247,290	647	73.00
74.00	07400	RENAL DIALYSIS	162,670	4,829,656	0.033681	9,217	310	74.00
76.00	03550	OP PSYCH	38,406	442,019	0.086888	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	139,446	15,030,896	0.009277	337,330	3,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,990,560	0.000000	0	0	92.00
93.01	04950	CANCER CENTER	0	0	0.000000	0	0	93.01
200.00		Total (lines 50 through 199)	1,180,820	146,512,812		1,042,766	5,447	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177
Component CCN: 14-S177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/14/2021 2:33 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.01	03190	CHEMO THERAPY	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	OP PSYCH	0	0	0	0	0	76.00
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								
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
93.01	04950	CANCER CENTER	0	0	0	0	0	93.01
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: 14-0177 Component CCN: 14-S177		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part IV Date/Time Prepared: 8/14/2021 2:33 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,685,373	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,383,440	0.000000	54.00
55.01	03190	CHEMO THERAPY	0	0	0	229,925	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	908,078	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	16,813,014	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	42,744,064	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	18,352,971	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,288,694	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,295,549	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	823,560	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	201,582	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,493,431	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,829,656	0.000000	74.00
76.00	03550	OP PSYCH	0	0	0	442,019	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	15,030,896	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,990,560	0.000000	92.00
93.01	04950	CANCER CENTER	0	0	0	0	0.000000	93.01
200.00		Total (lines 50 through 199)	0	0	0	146,512,812		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0177

Component CCN: 14-S177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/14/2021 2:33 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	2,308	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	13,234	0	1,998	0	54.00
55.01	03190	CHEMO THERAPY	0.000000	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	28,698	0	3,086	0	57.00
60.00	06000	LABORATORY	0.000000	358,495	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	36,978	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,245	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,457	0	236	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	514	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	247,290	0	70	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	9,217	0	0	0	74.00
76.00	03550	OP PSYCH	0.000000	0	0	0	0	76.00
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								
91.00	09100	EMERGENCY	0.000000	337,330	0	31,408	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0.000000	0	0	0	0	93.01
200.00		Total (lines 50 through 199)		1,042,766	0	36,798	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0177 Component CCN: 14-S177		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part V Date/Time Prepared: 8/14/2021 2:33 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.423689	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226828	1,998	0	0	453	54.00
55.01	03190	CHEMO THERAPY	0.014165	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.478239	0	0	0	0	56.00
57.00	05700	CT SCAN	0.037196	3,086	0	0	115	57.00
60.00	06000	LABORATORY	0.115700	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	0.117017	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.681533	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.121176	236	0	0	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.096556	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174885	70	0	0	12	73.00
74.00	07400	RENAL DIALYSIS	0.134165	0	0	0	0	74.00
76.00	03550	OP PSYCH	0.925637	0	0	0	0	76.00
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								
91.00	09100	EMERGENCY	0.384114	31,408	0	0	12,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.274971	0	0	0	0	92.00
93.01	04950	CANCER CENTER	0.000000	0	0	0	0	93.01
200.00		Subtotal (see instructions)		36,798	0	0	12,673	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		36,798	0	0	12,673	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0177

Period:

Worksheet D

Component CCN: 14-S177

From 04/01/2020
To 03/31/2021Part V
Date/Time Prepared:
8/14/2021 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.01	03190	CHEMO THERAPY	0	0		55.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03550	OP PSYCH	0	0		76.00
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						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.01	04950	CANCER CENTER	0	0		93.01
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/14/2021 2:33 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)		15,387	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,387	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)		13,172	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,282	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)		17,173,258	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)		17,173,258	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)		17,173,258	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)		1,116.09	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,663,007	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,663,007	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,783,273	1,989	2,404.86	563	1,353,936		43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,624,866		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,641,809		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)					251,862		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					193,556		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					445,418		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,196,391		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)					2,215		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,116.09		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,472,139		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/14/2021 2:33 pm

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	1,044,375	17,173,258	0.060814	2,472,139	150,341
91.00	Nursing School cost	0	17,173,258	0.000000	2,472,139	0
92.00	Allied health cost	0	17,173,258	0.000000	2,472,139	0
93.00	All other Medical Education	0	17,173,258	0.000000	2,472,139	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/14/2021 2:33 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)		13,604	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,604	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)		13,604	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,525	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,219,573	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,219,573	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,219,573	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)		751.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,145,611	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)		1,145,611	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/14/2021 2:33 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					227,523
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,373,134
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					88,374
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,447
52.00 Total Program excludable cost (sum of lines 50 and 51)					93,821
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,279,313
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: 14-0177 Component CCN: 14-S177		Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/14/2021 2:33 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	788,367	10,219,573	0.077143	0	0	90.00
91.00	Nursing School cost	0	10,219,573	0.000000	0	0	91.00
92.00	Allied health cost	0	10,219,573	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,219,573	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/14/2021 2:33 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)		15,387	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,387	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)		13,172	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)		690	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)		17,173,258	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)		17,173,258	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)		17,173,258	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)		1,116.09	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		770,102	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)		770,102	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		Title XIX		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,783,273	1,989	2,404.86	104	250,105
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					578,245
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,598,452
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)					2,215
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,116.09
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,472,139

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/14/2021 2:33 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	1,044,375	17,173,258	0.060814	2,472,139	150,341	90.00
91.00	Nursing School cost	0	17,173,258	0.000000	2,472,139	0	91.00
92.00	Allied health cost	0	17,173,258	0.000000	2,472,139	0	92.00
93.00	All other Medical Education	0	17,173,258	0.000000	2,472,139	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/14/2021 2:33 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		6,390,259	30.00
31.00	03100	INTENSIVE CARE UNIT		3,912,746	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.423689	719,907	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226828	1,463,765	54.00
55.01	03190	CHEMO THERAPY	0.014165	19,376	55.01
56.00	05600	RADIOISOTOPE	0.478239	193,019	56.00
57.00	05700	CT SCAN	0.037196	1,831,931	57.00
60.00	06000	LABORATORY	0.115700	6,123,366	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117017	4,759,163	65.00
66.00	06600	PHYSICAL THERAPY	0.681533	153,063	66.00
69.00	06900	ELECTROCARDIOLOGY	0.121176	486,223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377	82,800	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.096556	33,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174885	3,121,183	73.00
74.00	07400	RENAL DIALYSIS	0.134165	1,571,481	74.00
76.00	03550	OP PSYCH	0.925637	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.384114	1,018,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.274971	274,536	92.00
93.01	04950	CANCER CENTER	0.000000	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,851,280	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)		21,851,280	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/14/2021 2:33 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		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,936,521		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.423689	2,308	978	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.226828	13,234	3,002	54.00
55.01	03190 CHEMO THERAPY	0.014165	0	0	55.01
56.00	05600 RADIOISOTOPE	0.478239	0	0	56.00
57.00	05700 CT SCAN	0.037196	28,698	1,067	57.00
60.00	06000 LABORATORY	0.115700	358,495	41,478	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.117017	36,978	4,327	65.00
66.00	06600 PHYSICAL THERAPY	0.681533	1,245	849	66.00
69.00	06900 ELECTROCARDIOLOGY	0.121176	7,457	904	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377	514	861	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.096556	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.174885	247,290	43,247	73.00
74.00	07400 RENAL DIALYSIS	0.134165	9,217	1,237	74.00
76.00	03550 OP PSYCH	0.925637	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.384114	337,330	129,573	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.274971	0	0	92.00
93.01	04950 CANCER CENTER	0.000000	0	0	93.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,042,766	227,523	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)		1,042,766		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/14/2021 2:33 pm
Cost Center Description			Title XIX	Hospital	Cost
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,725,000	30.00
31.00	03100	INTENSIVE CARE UNIT		416,000	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.423689	102,897	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226828	182,969	54.00
55.01	03190	CHEMO THERAPY	0.014165	0	55.01
56.00	05600	RADIOISOTOPE	0.478239	64,504	56.00
57.00	05700	CT SCAN	0.037196	460,829	57.00
60.00	06000	LABORATORY	0.115700	1,474,212	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117017	765,308	65.00
66.00	06600	PHYSICAL THERAPY	0.681533	32,501	66.00
69.00	06900	ELECTROCARDIOLOGY	0.121176	146,418	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377	8,921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.096556	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174885	633,371	73.00
74.00	07400	RENAL DIALYSIS	0.134165	60,985	74.00
76.00	03550	OP PSYCH	0.925637	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.384114	7,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.274971	30,913	92.00
93.01	04950	CANCER CENTER	0.000000	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,971,010	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)		3,971,010	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/14/2021 2:33 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.423689	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.226828	0	0	54.00
55.01	03190 CHEMO THERAPY	0.014165	0	0	55.01
56.00	05600 RADIOISOTOPE	0.478239	0	0	56.00
57.00	05700 CT SCAN	0.037196	0	0	57.00
60.00	06000 LABORATORY	0.115700	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.117017	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.681533	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.121176	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.674377	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.096556	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.174885	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.134165	0	0	74.00
76.00	03550 OP PSYCH	0.925637	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.384114	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.274971	0	0	92.00
93.01	04950 CANCER CENTER	0.000000	0	0	93.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A
Date/Time Prepared:
8/14/2021 2:33 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)			2,680,045	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,039,646	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)			522,714	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			197,418	2.04
3.00	Managed Care Simulated Payments			1,075,874	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			102.87	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)			11.29	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			11.29	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			14.77	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			11.29	12.00
13.00	Total allowable FTE count for the prior year.			11.29	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.			11.29	14.00
15.00	Sum of lines 12 through 14 divided by 3.			11.29	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			11.29	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.109750	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.104828	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.104828	21.00
22.00	IME payment adjustment (see instructions)			262,509	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			59,840	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)			3.48	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)			262,509	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			59,840	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			16.46	30.00
31.00	Percentage of Medicaid patient days (see instructions)			43.01	31.00
32.00	Sum of lines 30 and 31			59.47	32.00
33.00	Allowable disproportionate share percentage (see instructions)			38.28	33.00
34.00	Disproportionate share adjustment (see instructions)			451,674	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part A Date/Time Prepared: 8/14/2021 2:33 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)	1,857,365	973,782		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	928,683	485,557		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,414,240			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	7,568,246			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		7,628,086		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		461,958		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).		278,483		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,368,527		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,368,527		61.00
62.00	Deductibles billed to program beneficiaries		468,888		62.00
63.00	Coinsurance billed to program beneficiaries		77,744		63.00
64.00	Allowable bad debts (see instructions)		533,849		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		347,002		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		279,041		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,168,897		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)		-17,848		70.93
70.94	HRR adjustment amount (see instructions)		-9,264		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A
Date/Time Prepared:
8/14/2021 2:33 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)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,141,785	71.00	
71.01	Sequestration adjustment (see instructions)		13,027	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		7,563,667	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		565,091	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		112,239	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/14/2021 2:33 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,680,045	0	2,680,045		2,680,045
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,039,646	0		2,039,646	2,039,646
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	522,714	0	522,714		522,714
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	197,418	0		197,418	197,418
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	1,075,874	0	622,387	453,487	1,075,874
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.104828	0.104828	0.104828	0.104828	
6.00	IME payment adjustment (see instructions)	22.00	262,509	0	149,064	113,445	262,509
6.01	IME payment adjustment for managed care (see instructions)	22.01	59,840	0	34,617	25,223	59,840
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	262,509	0	149,064	113,445	262,509
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	59,840	0	34,617	25,223	59,840
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3828	0.3828	0.3828	0.3828	
11.00	Disproportionate share adjustment (see instructions)	34.00	451,674	0	256,480	195,194	451,674
11.01	Uncompensated care payments	36.00	1,414,240	0	928,683	485,557	1,414,240
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	7,568,246	0	4,536,986	3,031,260	7,568,246
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,628,086	0	4,571,603	3,056,483	7,628,086
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	461,958	0	268,359	193,599	461,958

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/14/2021 2:33 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	4,839,962	3,250,082	8,090,044
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	368,284	0	212,273	156,011	368,284
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	17,218	0	12,018	5,200	17,218
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0797	0.0797	0.0797	0.0797	
23.00	Indirect medical education adjustment (see instructions)	6.00	29,352	0	16,918	12,434	29,352
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1279	0.1279	0.1279	0.1279	
25.00	Disproportionate share adjustment (see instructions)	11.00	47,104	0	27,150	19,954	47,104
26.00	Total prospective capital payments (see instructions)	12.00	461,958	0	268,359	193,599	461,958
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/14/2021 2:33 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	2,680,045	2,680,045	2,680,045	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,039,646	2,039,646	2,039,646	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	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	522,714	522,714	522,714	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	197,418	197,418	197,418	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,075,874	622,387	453,487	1,075,874
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.104828	0.104828	0.104828	5.00
6.00	IME payment adjustment (see instructions)	22.00	262,509	149,064	113,445	262,509
6.01	IME payment adjustment for managed care (see instructions)	22.01	59,840	34,617	25,223	59,840
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	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	262,509	149,064	113,445	262,509
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	59,840	34,617	25,223	59,840
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3828	0.3828	0.3828	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	451,674	256,480	195,194	451,674
11.01	Uncompensated care payments	36.00	1,414,240	928,683	485,557	1,414,240
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	7,568,246	4,536,986	3,031,260	7,568,246
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,628,086	4,571,603	3,056,483	7,628,086
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	461,958	268,359	193,599	461,958
17.00	Special add-on payments for new technologies	54.00	0	0	0	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	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00
19.00	SUBTOTAL			4,839,962	3,250,082	8,090,044

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/14/2021 2:33 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	368,284	212,273	156,011	368,284	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	17,218	12,018	5,200	17,218	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	0.0797	0.0797	0.0797		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	29,352	16,918	12,434	29,352	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1279	0.1279	0.1279		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	47,104	27,150	19,954	47,104	25.00
26.00	Total prospective capital payments (see instructions)	12.00	461,958	268,359	193,599	461,958	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	-17,848	-17,848	0	-17,848	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	-9,264	-8,040	-1,224	-9,264	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/14/2021 2:33 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		145	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,066,329	2.00
3.00	OPPS payments		490,096	3.00
4.00	Outlier payment (see instructions)		8,906	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)		145	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,250	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)		1,250	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)		1,250	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,105	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)		145	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)		499,002	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)		103,612	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)		395,535	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		30,007	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)		425,542	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		425,542	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)		291,473	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		189,457	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,585	36.00
37.00	Subtotal (see instructions)		614,999	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)		614,999	40.00
40.01	Sequestration adjustment (see instructions)		984	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		475,433	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)		138,582	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: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/14/2021 2:33 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 OPPS (see instructions)		12,673	2.00
3.00	OPPS payments		7,217	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		7,217	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)		1,444	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)		5,773	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)		5,773	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,773	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)		5,773	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)		5,773	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		5,768	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-4	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part I
Date/Time Prepared:
8/14/2021 2:33 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		7,563,667		475,433	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)		7,563,667		475,433	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		565,091		138,582	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,128,758		614,015	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: 14-0177

Period:

Worksheet E-1

Component CCN: 14-S177

From 04/01/2020
To 03/31/2021Part I
Date/Time Prepared:
8/14/2021 2:33 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					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		1,153,565		5,768	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)		0		0	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)		1,153,565		5,768	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		59,565		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		4	6.02
7.00	Total Medicare program liability (see instructions)		1,213,130		5,764	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: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part II
Date/Time Prepared:
8/14/2021 2:33 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: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet E-3 Part II Date/Time Prepared: 8/14/2021 2:33 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)			1,425,132 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)			37.271233 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)			1,425,132 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,425,132 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,425,132 18.00
19.00	Deductibles			203,692 19.00
20.00	Subtotal (line 18 minus line 19)			1,221,440 20.00
21.00	Coinsurance			66,366 21.00
22.00	Subtotal (line 20 minus line 21)			1,155,074 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			92,308 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			60,000 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,869 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,215,074 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)			1,215,074 31.00
31.01	Sequestration adjustment (see instructions)			1,944 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,153,565 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)			59,565 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: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 8/14/2021 2:33 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		1,598,452		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)		1,598,452	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)		1,598,452	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,141,000		8.00
9.00	Ancillary service charges		3,971,010	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)		6,112,010	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)		6,112,010	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,513,558	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,598,452	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)		1,598,452	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,598,452	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		1,598,452	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-351,602	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,246,850	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)		1,246,850	0	40.00
41.00	Interim payments		1,246,850	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		43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0177 Component CCN: 14-S177	Period: From 04/01/2020 To 03/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 8/14/2021 2:33 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	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	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)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0177		Period: From 04/01/2020 To 03/31/2021		Worksheet E-4 Date/Time Prepared: 8/14/2021 2:33 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.					11.29	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					11.29	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					14.77	6.00
7.00	Enter the lesser of line 5 or line 6					11.29	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.	14.77	0.00	14.77		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.	11.29	0.00	11.29		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01	
11.00	Total weighted FTE count	11.29	0.00	11.29		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	11.29	0.00	11.29		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.29	0.00	11.29		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	11.29	0.00	11.29		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	0.00		16.01	
17.00	Adjusted rolling average FTE count	11.29	0.00	11.29		17.00	
18.00	Per resident amount	126,155.35	119,586.08	245,741.43		18.00	
19.00	Approved amount for resident costs	1,424,294	0	1,424,294		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)					3.48	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)					1,424,294	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)	5,370	520	405			26.00
27.00	Total Inpatient Days (see instructions)	28,765	28,765	28,765			27.00
28.00	Ratio of inpatient days to total inpatient days	0.186685	0.018078	0.014080			28.00
29.00	Program direct GME amount	265,894	25,748	20,054	311,696		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		1,802	1,404	3,206		30.00
31.00	Net Program direct GME amount				308,490		31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet E-4 Date/Time Prepared: 8/14/2021 2:33 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)		4,829,656		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		10,014,943		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		10,014,943		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		1,079,147		42.00
43.00	Primary payer payments (see instructions)		0		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		1,079,147		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		11,094,090		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.902728		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.097272		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		308,490		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		278,483		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		30,007		50.00

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

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet G

Date/Time Prepared:
8/14/2021 2:33 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	16,856,719	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	47,321,317	0	0	0	4.00
5.00	Other receivable	763,234	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-42,678,409	0	0	0	6.00
7.00	Inventory	1,356,420	0	0	0	7.00
8.00	Prepaid expenses	552,600	0	0	0	8.00
9.00	Other current assets	74,338,943	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	98,510,824	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,482,024	0	0	0	12.00
13.00	Land improvements	126,454	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	60,775,943	0	0	0	15.00
16.00	Accumulated depreciation	-45,042,349	0	0	0	16.00
17.00	Leasehold improvements	3,178	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	199,394	0	0	0	21.00
22.00	Accumulated depreciation	-174,648	0	0	0	22.00
23.00	Major movable equipment	35,373,882	0	0	0	23.00
24.00	Accumulated depreciation	-31,931,380	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)	21,812,498	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	492,033	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	492,033	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	120,815,355	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,903,234	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,957,510	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,077,229	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	17,102,860	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,040,833	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,098,746	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,098,746	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,139,579	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	78,675,776	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)	78,675,776	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	120,815,355	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-1

Date/Time Prepared:
8/14/2021 2:33 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		71,929,689		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,746,087				2.00
3.00	Total (sum of line 1 and line 2)		78,675,776		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)		78,675,776		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		78,675,776		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			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: 14-0177

Period:
From 04/01/2020
To 03/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
8/14/2021 2:33 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	25,406,843		25,406,843	1.00
2.00	SUBPROVIDER - IPF	16,989,283		16,989,283	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	42,396,126		42,396,126	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	16,807,178		16,807,178	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	16,807,178		16,807,178	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	59,203,304		59,203,304	17.00
18.00	Ancillary services	82,117,164	0	82,117,164	18.00
19.00	Outpatient services	0	63,373,381	63,373,381	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	141,320,468	63,373,381	204,693,849	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		79,294,480		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		79,294,480		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0177

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-3

Date/Time Prepared:
8/14/2021 2:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	204,693,849	1.00
2.00	Less contractual allowances and discounts on patients' accounts	127,202,985	2.00
3.00	Net patient revenues (line 1 minus line 2)	77,490,864	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	79,294,480	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,803,616	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	6,000	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	210,098	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,610	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	505,440	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEDICAL SCHOOL BILLINGS	557,407	24.00
24.01	RESTRICTED REVENUE	2,097,699	24.01
24.02	RADIOLOGY PHYSICIAN REVENUE	348,526	24.02
24.03	MISC. INCOME	107,899	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.50	COVID-19 PHE Funding	4,714,024	24.50
25.00	Total other income (sum of lines 6-24)	8,549,703	25.00
26.00	Total (line 5 plus line 25)	6,746,087	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)	6,746,087	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0177	Period: From 04/01/2020 To 03/31/2021	Worksheet L Parts I-III Date/Time Prepared: 8/14/2021 2:33 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		368,284	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,218	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)		41.54	3.00
4.00	Number of interns & residents (see instructions)		11.29	4.00
5.00	Indirect medical education percentage (see instructions)		7.97	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)		29,352	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		16.46	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		43.01	8.00
9.00	Sum of lines 7 and 8		59.47	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.79	10.00
11.00	Disproportionate share adjustment (see instructions)		47,104	11.00
12.00	Total prospective capital payments (see instructions)		461,958	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