

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: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 3:20 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2021	Time: 3:20 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 PRESENCE SAINTS MARY & ELIZABETH MED (14-0180) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ERIC ZORNOW
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	499,484	-757	0	0	1.00
2.00	Subprovider - IPF	0	12,553	50		0	2.00
3.00	Subprovider - IRF	0	1,495	78		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	513,532	-629	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: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:20 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2233 WEST DIVISION STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60622		County: COOK 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PRESENCE SAINTS MARY & ELIZABETH MED	140180	16974	1	07/01/1966	N P O
4.00	Subprovider - IPF			PRESENCE ST MARY AND ELIZABETH PSYCH	14S180	16974	4	01/01/2018	N P O
5.00	Subprovider - IRF			ST. MARY OF NAZARETH REHAB UNIT	14T180	16974	5	01/01/1984	N P O
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF			ST. ELIZABETH'S SNF	145541	16974		12/28/1986	N P N
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)						07/01/2020	06/30/2021	
21.00	Type of Control (see instructions)						1		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		

Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

MCRIF32 - 16.12.172.7

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:20 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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)					Y	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	8.13	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)	FAMILY MEDICINE	1350	0.00	36.48	0.000000	67.00
67.01		INTERNAL MEDICINE	1400	0.00	13.19	0.000000	67.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:20 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				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

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00			
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			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	7,142,428		0		0118.01	
				1.00			
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.	Y		5.00		122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:20 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149013		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ALEXIAN BROTHERS HEALTH SYSTEMS	Contractor's Name: WPS		Contractor's Number: 05901		141.00	
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606		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	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 3:20 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 3:20 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					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.	Y					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.	Y					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/13/2020	Y	11/13/2020		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 3:20 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718	PATRICK.GILLILAND@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 3:20 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR		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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 3:20 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	277	111,820	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)		277	111,820	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	17	6,205	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)		294	118,025	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF	41.00	15	5,475		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		323			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)		8	2,920			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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 3:20 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)	15,328	6,495	68,136			1.00
2.00	HMO and other (see instructions)	10,447	28,070				2.00
3.00	HMO IPF Subprovider	291	1,404				3.00
4.00	HMO IRF Subprovider	28	1,041				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)	15,328	6,495	68,136			7.00
8.00	INTENSIVE CARE UNIT	1,074	469	5,104			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		483	2,076			13.00
14.00	Total (see instructions)	16,402	7,447	75,316	57.80	1,030.94	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	450	1,404	2,980	0.00	15.09	16.00
17.00	SUBPROVIDER - IRF	1,316	38	4,173	0.00	17.50	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			85			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)				57.80	1,063.53	27.00
28.00	Observation Bed Days		1,081	2,845			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	323	468			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			22			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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 3:20 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	2,223	3,054	9,249	1.00
2.00 HMO and other (see instructions)			1,487	2,320		2.00
3.00 HMO IPF Subprovider				2,578		3.00
4.00 HMO IRF Subprovider				82		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	2,223	3,054	9,249	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	40	3,048	3,214	16.00
17.00 SUBPROVIDER - IRF	0.00	0	107	85	326	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 3:20 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	89,671,058	0	89,671,058	2,332,375.00	38.45
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		302,758	0	302,758	1,731.75	174.83
4.01	Physicians - Part A - Teaching		744,357	0	744,357	33,096.55	22.49
5.00	Physician and Non Physician-Part B		1,379,107	0	1,379,107	76,636.00	18.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	2,462,751	2,462,751	82,034.37	30.02
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,913,645	0	3,913,645	101,673.00	38.49
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		9,070,875	0	9,070,875	156,734.00	57.87
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		82,869	0	82,869	325.00	254.98
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	14.00
14.01	Home office salaries		87,943,104	0	87,943,104	1,316,184.00	66.82
14.02	Related organization salaries		0	0	0	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		18,218,185	0	18,218,185		17.00
18.00	Wage-related costs (other) (see instructions)						18.00
19.00	Excluded areas		663,796	0	663,796		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		32,128	0	32,128		22.00
22.01	Physician Part A - Teaching		252,020	0	252,020		22.01
23.00	Physician Part B		558,826	0	558,826		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		529,704	0	529,704		25.00
25.50	Home office wage-related (core)		0	0	0		25.50
25.51	Related organization wage-related (core)		0	0	0		25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 3:20 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	861,780	0	861,780	15,355.49	56.12	26.00
27.00	Administrative & General	5.00	5,741,397	0	5,741,397	113,865.13	50.42	27.00
28.00	Administrative & General under contract (see inst.)		615,193	0	615,193	2,748.46	223.83	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	72,409.01	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		5,607,332	0	5,607,332	223,710.00	25.07	33.00
34.00	Dietary	10.00	194,005	-104,501	89,504	4,136.97	21.64	34.00
35.00	Dietary under contract (see instructions)		3,925,613	0	3,925,613	144,936.00	27.09	35.00
36.00	Cafeteria	11.00	0	104,501	104,501	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,679,925	0	1,679,925	31,951.71	52.58	38.00
39.00	Central Services and Supply	14.00	430,115	0	430,115	20,805.38	20.67	39.00
40.00	Pharmacy	15.00	3,905,505	0	3,905,505	84,185.43	46.39	40.00
41.00	Medical Records & Medical Records Library	16.00	380,005	0	380,005	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/30/2021 3:20 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)	97,695,732	-2,462,751	95,232,981	2,512,002.54	37.91	1.00
2.00	Excluded area salaries (see instructions)	3,913,645	0	3,913,645	101,673.00	38.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	93,782,087	-2,462,751	91,319,336	2,410,329.54	37.89	3.00
4.00	Subtotal other wages & related costs (see inst.)	97,096,848	0	97,096,848	1,473,243.00	65.91	4.00
5.00	Subtotal wage-related costs (see inst.)	18,250,313	0	18,250,313	0.00	19.99	5.00
6.00	Total (sum of lines 3 thru 5)	209,129,248	-2,462,751	206,666,497	3,883,572.54	53.22	6.00
7.00	Total overhead cost (see instructions)	23,340,870	0	23,340,870	714,103.58	32.69	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2021 3:20 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		3,810,843	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		2,375,984	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		120,923	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		48,517	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)		6,211,259	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,098,002	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		6,438,377	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		73,941	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		76,814	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		20,254,660	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0180

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 11/30/2021 3:20 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	5,043,729	20,254,660	1.00
2.00	Hospital	5,043,729	18,218,185	2.00
3.00	Subprovider - IPF	0	186,140	3.00
4.00	Subprovider - IRF	0	190,435	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	1,659,900	18.00

Health Financial Systems		PRESENCE SAINTS MARY & ELIZABETH MED		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 3:20 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)	0.188181		1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	144,112,202		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	489,238,816		6.00	
7.00	Medicaid cost (line 1 times line 6)	92,065,450		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)	57,363,104	3,982,766	61,345,870	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,794,646	3,982,766	14,777,412	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	10,794,646	3,982,766	14,777,412	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,189,121		26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,557,450		27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	2,396,076		27.01	
28.00	Non-Medicare bad debt expense (see instructions)	3,793,045		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,552,405		29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	16,329,817		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	16,329,817		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0180

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

Worksheet A

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	10,847,146	10,847,146	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,112,559	3,112,559	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	861,780	14,071,041	14,932,821	-4,457	14,928,364	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,741,397	92,577,885	98,319,282	-5,355,164	92,964,118	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	6,859,945	6,859,945	-788,294	6,071,651	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	929,674	929,674	0	929,674	8.00
9.00	00900	HOUSEKEEPING	0	4,798,933	4,798,933	-12,160	4,786,773	9.00
10.00	01000	DIETARY	194,005	6,275,678	6,469,683	-3,486,438	2,983,245	10.00
11.00	01100	CAFETERIA	0	3,256	3,256	3,489,600	3,492,856	11.00
13.00	01300	NURSING ADMINISTRATION	1,679,925	1,781,031	3,460,956	-217,939	3,243,017	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	430,115	842,439	1,272,554	-229,776	1,042,778	14.00
15.00	01500	PHARMACY	3,905,505	9,875,834	13,781,339	-9,118,187	4,663,152	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380,005	1,045,628	1,425,633	-32,816	1,392,817	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,462,751	2,462,751	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,156,911	1,318,178	6,475,089	-2,463,514	4,011,575	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	232,444	24,087	256,531	0	256,531	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,793,937	12,840,325	44,634,262	-1,584,523	43,049,739	30.00
31.00	03100	INTENSIVE CARE UNIT	3,877,598	3,046,747	6,924,345	-754,838	6,169,507	31.00
40.00	04000	SUBPROVIDER - IPF	1,303,775	613,262	1,917,037	-21,329	1,895,708	40.00
41.00	04100	SUBPROVIDER - IRF	1,342,638	174,307	1,516,945	-17,551	1,499,394	41.00
43.00	04300	NURSERY	780,421	134,684	915,105	-29,643	885,462	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,326,622	13,340,781	19,667,403	-7,616,049	12,051,354	50.00
51.00	05100	RECOVERY ROOM	835,826	105,327	941,153	-34,702	906,451	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,777,353	810,346	4,587,699	-368,891	4,218,808	52.00
53.00	05300	ANESTHESIOLOGY	120,244	3,178,621	3,298,865	-354,340	2,944,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,139,846	1,457,362	4,597,208	-640,743	3,956,465	54.00
54.01	03190	OUTPATIENT ONCOLOGY	1,285,082	9,407,730	10,692,812	-8,871,041	1,821,771	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	171,590	1,007,066	1,178,656	-394,255	784,401	55.00
57.00	05700	CT SCAN	729,128	100,922	830,050	-19,140	810,910	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,478	339,994	635,472	-206,295	429,267	58.00
59.00	05900	CARDIAC CATHETERIZATION	507,545	884,400	1,391,945	-677,150	714,795	59.00
60.00	06000	LABORATORY	0	11,153,897	11,153,897	-193,914	10,959,983	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	124,504	16,605	141,109	-224	140,885	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,485,693	829,291	2,314,984	-391,386	1,923,598	65.00
66.00	06600	PHYSICAL THERAPY	2,655,936	261,582	2,917,518	-39,147	2,878,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	883,802	70,280	954,082	-3,244	950,838	67.00
68.00	06800	SPEECH PATHOLOGY	253,075	19,495	272,570	0	272,570	68.00
69.00	06900	ELECTROCARDIOLOGY	972,157	218,661	1,190,818	-80,902	1,109,916	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	171,674	345,653	517,327	-19,096	498,231	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,861,779	7,861,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,213,383	5,213,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,404,768	9,404,768	73.00
74.00	07400	RENAL DIALYSIS	27,322	861,290	888,612	-850,190	38,422	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	720,494	4,241,537	4,962,031	-366,484	4,595,547	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	7,750	32,975	40,725	-40,725	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	315,330	250,649	565,979	-28,296	537,683	90.00
91.00	09100	EMERGENCY	6,149,363	4,288,344	10,437,707	-935,578	9,502,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		4,618,422	4,618,422	-4,618,422	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,636,270	215,054,164	303,690,434	-8,474,767	295,215,667	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	132,232	-290,649	-158,417	0	-158,417	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	32,223	32,223	194.00
194.01	07951	OUTPATIENT PHARMACY	902,556	5,776,515	6,679,071	8,442,544	15,121,615	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0180

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

Worksheet A

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	89,671,058	220,540,030	310,211,088	0	310,211,088	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0180

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

Worksheet A

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,326,890	4,520,256	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	10,083,502	13,196,061	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,144,259	8,784,105	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,290,686	72,673,432	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,202,789	13,274,440	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,884	948,558	8.00
9.00	00900	HOUSEKEEPING	0	4,786,773	9.00
10.00	01000	DIETARY	0	2,983,245	10.00
11.00	01100	CAFETERIA	-801,274	2,691,582	11.00
13.00	01300	NURSING ADMINISTRATION	203,672	3,446,689	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,042,778	14.00
15.00	01500	PHARMACY	21,355	4,684,507	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-521,821	870,996	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	2,462,751	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	4,011,575	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	256,531	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,795,749	38,253,990	30.00
31.00	03100	INTENSIVE CARE UNIT	17,679	6,187,186	31.00
40.00	04000	SUBPROVIDER - IPF	631,085	2,526,793	40.00
41.00	04100	SUBPROVIDER - IRF	-22,863	1,476,531	41.00
43.00	04300	NURSERY	-35,874	849,588	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-557,062	11,494,292	50.00
51.00	05100	RECOVERY ROOM	0	906,451	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-912,523	3,306,285	52.00
53.00	05300	ANESTHESIOLOGY	-2,765,244	179,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,580	3,945,885	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	1,821,771	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	18,565	802,966	55.00
57.00	05700	CT SCAN	0	810,910	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	429,267	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	714,795	59.00
60.00	06000	LABORATORY	-23,322	10,936,661	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	140,885	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-13,853	1,909,745	65.00
66.00	06600	PHYSICAL THERAPY	0	2,878,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	950,838	67.00
68.00	06800	SPEECH PATHOLOGY	0	272,570	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,374	1,107,542	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-309,893	188,338	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,861,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,213,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,404,768	73.00
74.00	07400	RENAL DIALYSIS	0	38,422	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,595,547	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	537,683	90.00
91.00	09100	EMERGENCY	-1,709,917	7,792,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-27,046,653	268,169,014	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-158,417	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	CONVENT	0	32,223	194.00
194.01	07951	OUTPATIENT PHARMACY	0	15,121,615	194.01
194.02	07952	FUND DEVELOPMENT	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0180

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

Worksheet A

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	-27,046,653	283,164,435	200.00

RECLASSIFICATIONS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/30/2021 3:20 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CONTRACT PHARM RCL					
1.00	OUTPATIENT PHARMACY	194.01	0	8,442,544		1.00
	TOTALS		0	8,442,544		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,847,312		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	17,847,312		
	C - SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,861,779		1.00
2.00	DIETARY	10.00	0	8,640		2.00
3.00	CAFETERIA	11.00	0	258		3.00
4.00	PHARMACY	15.00	0	15,176		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	150,624		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
	TOTALS		0	8,036,477		
	D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,213,383		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00

RECLASSIFICATIONS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/30/2021 3:20 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	TOTALS		0	5,213,383		
	E - MORTGAGE INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,618,422		1.00
	TOTALS		0	4,618,422		
	F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,228,724		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,112,559		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
	TOTALS		0	9,341,283		
	G - PHONE					
1.00	OPERATION OF PLANT	7.00	0	175,393		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	175,393		
	H - CAFETERIA					
1.00	CAFETERIA	11.00	104,501	3,385,224		1.00
	TOTALS		104,501	3,385,224		
	I - INTERNS RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,462,751	0		1.00
	TOTALS		2,462,751	0		
	J - CONVENT MAINT					
1.00	CONVENT	194.00	0	32,223		1.00
	TOTALS		0	32,223		
	K - CARDIAC REHAB					
1.00	ELECTROCARDIOLOGY	69.00	7,750	32,975		1.00
	TOTALS		7,750	32,975		
500.00	Grand Total: Increases		2,575,002	57,125,236		500.00

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 3:20 pm

	Decreases							11/30/2021 3:20 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - CONTRACT PHARM RCL							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,442,544	0			1.00
	TOTALS		0	8,442,544				
	B - DRUGS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	241,749	0			1.00
2.00	OPERATION OF PLANT	7.00	0	1	0			2.00
3.00	HOUSEKEEPING	9.00	0	4	0			3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,564	0			4.00
5.00	PHARMACY	15.00	0	9,042,621	0			5.00
6.00	ADULTS & PEDIATRICS	30.00	0	540	0			6.00
7.00	INTENSIVE CARE UNIT	31.00	0	53	0			7.00
8.00	OPERATING ROOM	50.00	0	2,471	0			8.00
9.00	RECOVERY ROOM	51.00	0	62	0			9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	92	0			10.00
11.00	ANESTHESIOLOGY	53.00	0	1,736	0			11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,255	0			12.00
13.00	OUTPATIENT ONCOLOGY	54.01	0	8,444,461	0			13.00
14.00	CT SCAN	57.00	0	13,320	0			14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	52,645	0			15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	6,963	0			16.00
17.00	BLOOD CLOTTING FOR HEMOPHILIACS	62.30	0	76	0			17.00
18.00	RESPIRATORY THERAPY	65.00	0	3,993	0			18.00
19.00	PHYSICAL THERAPY	66.00	0	10	0			19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	2	0			20.00
21.00	ELECTROCARDIOLOGY	69.00	0	242	0			21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	3	0			22.00
23.00	CLINIC	90.00	0	2,506	0			23.00
24.00	EMERGENCY	91.00	0	4,943	0			24.00
	TOTALS		0	17,847,312				
	C - SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,457	0			1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	212,643	0			2.00
3.00	OPERATION OF PLANT	7.00	0	7,624	0			3.00
4.00	HOUSEKEEPING	9.00	0	4,125	0			4.00
5.00	NURSING ADMINISTRATION	13.00	0	8,114	0			5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	172,406	0			6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	31,983	0			7.00
8.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	763	0			8.00
9.00	ADULTS & PEDIATRICS	30.00	0	1,460,058	0			9.00
10.00	INTENSIVE CARE UNIT	31.00	0	568,229	0			10.00
11.00	SUBPROVIDER - IRF	41.00	0	12,218	0			11.00
12.00	NURSERY	43.00	0	24,907	0			12.00
13.00	OPERATING ROOM	50.00	0	2,471,929	0			13.00
14.00	RECOVERY ROOM	51.00	0	29,145	0			14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	255,913	0			15.00
16.00	ANESTHESIOLOGY	53.00	0	261,602	0			16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,539	0			17.00
18.00	OUTPATIENT ONCOLOGY	54.01	0	157,286	0			18.00
19.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,246	0			19.00
20.00	CT SCAN	57.00	0	5,820	0			20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	53,324	0			21.00
22.00	LABORATORY	60.00	0	89,700	0			22.00
23.00	BLOOD CLOTTING FOR HEMOPHILIACS	62.30	0	148	0			23.00
24.00	RESPIRATORY THERAPY	65.00	0	379,216	0			24.00
25.00	PHYSICAL THERAPY	66.00	0	23,669	0			25.00
26.00	OCCUPATIONAL THERAPY	67.00	0	3,242	0			26.00
27.00	ELECTROCARDIOLOGY	69.00	0	17,644	0			27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,903	0			28.00
29.00	RENAL DIALYSIS	74.00	0	834,457	0			29.00
30.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	135	0			30.00
31.00	ELECTROCARDIOLOGY	69.00	0	631	0			31.00
32.00	CLINIC	90.00	0	12,875	0			32.00
33.00	EMERGENCY	91.00	0	886,526	0			33.00
	TOTALS		0	8,036,477				
	D - IMPLANTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,409	0			2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,498	0			3.00

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 3:20 pm

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
4.00	NURSERY	43.00	0	4,736	0	4.00
5.00	OPERATING ROOM	50.00	0	4,576,558	0	5.00
6.00	RECOVERY ROOM	51.00	0	3,768	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	62,145	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	4	0	8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	558,521	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	18	0	10.00
11.00	EMERGENCY	91.00	0	690	0	11.00
	TOTALS		0	5,213,383		
E - MORTGAGE INTEREST						
1.00	INTEREST EXPENSE	113.00	0	4,618,422	11	1.00
	TOTALS		0	4,618,422		
F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,727,850	9	1.00
2.00	OPERATION OF PLANT	7.00	0	923,839	9	2.00
3.00	HOUSEKEEPING	9.00	0	8,031	0	3.00
4.00	DIETARY	10.00	0	2,846	0	4.00
5.00	CAFETERIA	11.00	0	383	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	209,825	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	54,806	0	7.00
8.00	PHARMACY	15.00	0	90,742	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	833	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	118,516	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	185,058	0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	21,329	0	12.00
13.00	SUBPROVIDER - IRF	41.00	0	5,333	0	13.00
14.00	OPERATING ROOM	50.00	0	565,091	0	14.00
15.00	RECOVERY ROOM	51.00	0	1,727	0	15.00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	50,741	0	16.00
17.00	ANESTHESIOLOGY	53.00	0	90,998	0	17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	575,949	0	18.00
19.00	OUTPATIENT ONCOLOGY	54.01	0	269,294	0	19.00
20.00	RADIOLOGY-THERAPEUTIC	55.00	0	390,009	0	20.00
21.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	100,236	0	21.00
22.00	CARDIAC CATHETERIZATION	59.00	0	262,290	0	22.00
23.00	LABORATORY	60.00	0	104,214	0	23.00
24.00	RESPIRATORY THERAPY	65.00	0	8,177	0	24.00
25.00	PHYSICAL THERAPY	66.00	0	15,468	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	0	103,092	0	26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	16,190	0	27.00
28.00	RENAL DIALYSIS	74.00	0	15,733	0	28.00
29.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	366,349	0	29.00
30.00	CLINIC	90.00	0	12,915	0	30.00
31.00	EMERGENCY	91.00	0	43,419	0	31.00
	TOTALS		0	9,341,283		
G - PHONE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	172,886	0	1.00
2.00	DIETARY	10.00	0	2,507	0	2.00
	TOTALS		0	175,393		
H - CAFETERIA						
1.00	DIETARY	10.00	104,501	3,385,224	0	1.00
	TOTALS		104,501	3,385,224		
I - INTERNS RESIDENTS						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	2,462,751	0	0	1.00
	TOTALS		2,462,751	0		
J - CONVENT MAINT						
1.00	OPERATION OF PLANT	7.00	0	32,223	0	1.00
	TOTALS		0	32,223		
K - CARDIAC REHAB						
1.00	CARDIAC REHABILITATION	76.97	7,750	32,975	0	1.00
	TOTALS		7,750	32,975		
500.00	Grand Total: Decreases		2,575,002	57,125,236		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	35,010,000	0	0	0	0	1.00	
2.00	Land Improvements	368,305	82,920	0	82,920	0	2.00	
3.00	Buildings and Fixtures	130,521,180	5,989,108	0	5,989,108	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	7,877,179	115,423	0	115,423	0	5.00	
6.00	Movable Equipment	22,047,098	2,663,960	0	2,663,960	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	195,823,762	8,851,411	0	8,851,411	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	195,823,762	8,851,411	0	8,851,411	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	35,010,000	0				1.00	
2.00	Land Improvements	451,225	0				2.00	
3.00	Buildings and Fixtures	136,510,288	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	7,992,602	0				5.00	
6.00	Movable Equipment	24,711,058	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	204,675,173	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	204,675,173	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 3:20 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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 3:20 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	179,964,115	0	179,964,115	0.879267	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,711,058	0	24,711,058	0.120733	0	2.00
3.00	Total (sum of lines 1-2)	204,675,173	0	204,675,173	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	4,520,256	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,196,061	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,716,317	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	4,520,256	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	13,196,061	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	17,716,317	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0180

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,453,300			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	-10,775,458			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-801,274	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-1,766,385	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	1,205,159	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE	B	-1,940	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0180

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	COST OFFSET - CONTRIBUTIONS	A		0 ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	COST OFFSET - CONTRIBUTIONS	A		0 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.02
33.03	MISC INCOME	B		0 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.03
33.04	MISC INCOME	B	-1,660,933	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC INCOME	B		0 OPERATING ROOM	50.00	0	33.05
33.06	MISC INCOME	B	1,614	DELIVERY ROOM & LABOR ROOM	52.00	0	33.06
33.07	MISC INCOME	B	-44,737	PHARMACY	15.00	0	33.07
33.08	MISC INCOME	B		0 CARDIAC REHABILITATION	76.97	0	33.08
33.09	MISC INCOME	B		0 ADULTS & PEDIATRICS	30.00	0	33.09
33.10	MISC INCOME	B	-9,918	MEDICAL RECORDS & LIBRARY	16.00	0	33.10
33.11	COST OFFSET - CONTRIBUTIONS	A	-591,484	MEDICAL RECORDS & LIBRARY	16.00	0	33.11
33.12	COST OFFSET - CONTRIBUTIONS	A		0 CLINIC	90.00	0	33.12
33.13	COST OFFSET - MARKETING	A		0 LABORATORY	60.00	0	33.13
33.14	COST OFFSET - MARKETING	A	-147,717	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	COST OFFSET - BUSINESS DEVELOPMENT	A	-280	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-27,046,653				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0180

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 3:20 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT INSURANCE	0	7,274,637	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIRECT WORKERS COMP	0	6,723,489	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST INCOME	-4,618,422	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	18,411,879	0	4.00
4.09	15.00	PHARMACY	PHARMACY ADMIN	66,092	0	4.09
4.10	40.00	SUBPROVIDER - IPF	BH INTAKE	731,836	0	4.10
4.11	55.00	RADIOLOGY-THERAPEUTIC	RADIATION ONCOLOGY	52,082	0	4.11
4.14	13.00	NURSING ADMINISTRATION	NURSING ADMINISTRATION	203,672	0	4.14
4.15	7.00	OPERATION OF PLANT	FACILITIES	7,202,789	0	4.15
4.17	31.00	INTENSIVE CARE UNIT	TELE ICU	1,139,715	0	4.17
4.18	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	579,230	0	4.18
4.19	16.00	MEDICAL RECORDS & LIBRARY	HEALTH INFORMATION MGMT	79,581	0	4.19
4.20	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE BUILDING	57,917	0	4.20
4.21	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE EQUIPMENT	3,151,228	0	4.21
4.22	2.00	CAP REL COSTS-MVBLE EQUIP	IS CAPITAL	5,727,115	0	4.22
4.23	5.00	ADMINISTRATIVE & GENERAL	POOLED NON CAPITAL	14,340,539	43,921,469	4.23
4.24	60.00	LABORATORY	ALVERNO	9,826,126	9,826,126	4.24
4.25	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	18,884	0	4.25
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			56,970,263	67,745,721	5.00

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

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

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

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

6.00	B	100.00	PRESENCE HEALTH	100.00	6.00
7.00	C	66.67	ALVERNO	66.67	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0180

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 3:20 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-7,274,637	0		1.00
2.00	-6,723,489	0		2.00
3.00	-4,618,422	11		3.00
4.00	18,411,879	0		4.00
4.09	66,092	0		4.09
4.10	731,836	0		4.10
4.11	52,082	0		4.11
4.14	203,672	0		4.14
4.15	7,202,789	0		4.15
4.17	1,139,715	0		4.17
4.18	579,230	0		4.18
4.19	79,581	0		4.19
4.20	57,917	9		4.20
4.21	3,151,228	9		4.21
4.22	5,727,115	9		4.22
4.23	-29,580,930	0		4.23
4.24	0	0		4.24
4.25	18,884	0		4.25
5.00	-10,775,458			5.00

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

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

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

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

6.00	SOLE CORPORATE MEMBER		6.00
7.00	LAB		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0180

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 3:20 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	70,403	19,274	51,129	211,500	318	1.00
2.00	30.00	ADULTS & PEDIATRICS	4,914,680	4,795,749	118,931	211,500	1,384	2.00
3.00	31.00	INTENSIVE CARE UNIT	1,122,036	1,122,036	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	101,453	100,751	702	211,500	26	4.00
5.00	41.00	SUBPROVIDER - IRF	43,200	10,200	33,000	211,500	200	5.00
6.00	43.00	NURSERY	35,874	35,874	0	0	0	6.00
7.00	50.00	OPERATING ROOM	630,982	391,982	239,000	246,400	624	7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	914,137	914,137	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	2,765,244	2,765,244	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	8,640	8,640	0	0	0	10.00
11.00	55.00	RADIOLOGY-THERAPEUTIC	51,900	33,517	18,383	271,900	156	11.00
12.00	60.00	LABORATORY	39,000	23,322	15,678	260,300	212	12.00
13.00	65.00	RESPIRATORY THERAPY	13,853	13,853	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	2,374	2,374	0	0	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	311,200	309,319	1,881	271,900	10	15.00
16.00	90.00	CLINIC	92,081	0	92,081	211,500	8,760	16.00
17.00	91.00	EMERGENCY	1,730,254	1,697,254	33,000	211,500	200	17.00
200.00			12,847,311	12,243,526	603,785		11,890	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	32,335	1,617	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	140,729	7,036	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	2,644	132	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	20,337	1,017	0	0	0	5.00
6.00	43.00	NURSERY	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	73,920	3,696	0	0	0	7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	10.00
11.00	55.00	RADIOLOGY-THERAPEUTIC	20,393	1,020	0	0	0	11.00
12.00	60.00	LABORATORY	26,531	1,327	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	1,307	65	0	0	0	15.00
16.00	90.00	CLINIC	890,740	44,537	0	0	0	16.00
17.00	91.00	EMERGENCY	20,337	1,017	0	0	0	17.00
200.00			1,229,273	61,464	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	32,335	18,794	38,068		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	140,729	0	4,795,749		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,122,036		3.00
4.00	40.00	SUBPROVIDER - IPF	0	2,644	0	100,751		4.00
5.00	41.00	SUBPROVIDER - IRF	0	20,337	12,663	22,863		5.00
6.00	43.00	NURSERY	0	0	0	35,874		6.00
7.00	50.00	OPERATING ROOM	0	73,920	165,080	557,062		7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	914,137		8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	2,765,244		9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	8,640		10.00
11.00	55.00	RADIOLOGY-THERAPEUTIC	0	20,393	0	33,517		11.00
12.00	60.00	LABORATORY	0	26,531	0	23,322		12.00
13.00	65.00	RESPIRATORY THERAPY	0	0	0	13,853		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,374		14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	0	1,307	574	309,893		15.00
16.00	90.00	CLINIC	0	890,740	0	0		16.00
17.00	91.00	EMERGENCY	0	20,337	12,663	1,709,917		17.00
200.00			0	1,229,273	209,774	12,453,300		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/30/2021 3:20 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	4,520,256	4,520,256			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,196,061		13,196,061		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,784,105	35,971	105,012	8,925,088	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	72,673,432	309,298	902,939	576,993	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,274,440	631,937	1,844,826	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	948,558	21,740	63,466	0	8.00
9.00	00900	HOUSEKEEPING	4,786,773	65,391	190,897	0	9.00
10.00	01000	DIETARY	2,983,245	129,820	378,984	8,995	10.00
11.00	01100	CAFETERIA	2,691,582	19,417	56,683	10,502	11.00
13.00	01300	NURSING ADMINISTRATION	3,446,689	99,525	290,546	168,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,042,778	97,559	284,805	43,225	14.00
15.00	01500	PHARMACY	4,684,507	35,185	102,715	392,492	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	870,996	61,111	178,403	38,189	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,462,751	11,214	32,738	247,499	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	4,011,575	0	0	270,755	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	256,531	0	0	23,360	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	38,253,990	1,051,328	3,069,160	3,195,217	30.00
31.00	03100	INTENSIVE CARE UNIT	6,187,186	52,164	152,283	389,687	31.00
40.00	04000	SUBPROVIDER - IPF	2,526,793	25,135	73,377	131,025	40.00
41.00	04100	SUBPROVIDER - IRF	1,476,531	42,864	125,135	134,931	41.00
43.00	04300	NURSERY	849,588	9,579	27,964	78,430	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,494,292	275,899	805,436	635,807	50.00
51.00	05100	RECOVERY ROOM	906,451	18,081	52,785	83,998	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,306,285	126,523	369,361	379,613	52.00
53.00	05300	ANESTHESIOLOGY	179,281	2,660	7,765	12,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,945,885	108,902	317,920	315,545	54.00
54.01	03190	OUTPATIENT ONCOLOGY	1,821,771	1,170	3,414	129,147	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	802,966	6,676	19,489	17,244	55.00
57.00	05700	CT SCAN	810,910	11,157	32,572	73,275	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	429,267	4,109	11,995	29,695	58.00
59.00	05900	CARDIAC CATHETERIZATION	714,795	28,416	82,955	51,007	59.00
60.00	06000	LABORATORY	10,936,661	105,647	308,418	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	140,885	0	0	12,512	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,909,745	5,858	17,102	149,308	65.00
66.00	06600	PHYSICAL THERAPY	2,878,371	46,249	135,015	266,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	950,838	4,978	14,533	88,819	67.00
68.00	06800	SPEECH PATHOLOGY	272,570	0	0	25,433	68.00
69.00	06900	ELECTROCARDIOLOGY	1,107,542	40,929	119,484	98,478	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	188,338	11,095	32,390	17,253	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,861,779	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,213,383	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,404,768	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	38,422	3,141	9,170	2,746	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,595,547	62,462	182,346	72,407	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	537,683	135,838	396,554	31,690	90.00
91.00	09100	EMERGENCY	7,792,212	821,228	2,397,424	617,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	268,169,014	4,520,256	13,196,061	8,821,095	268,065,021
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-158,417	0	0	13,289	-145,128
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.00	07950	CONVENT	32,223	0	0	0	32,223	194.00
194.01	07951	OUTPATIENT PHARMACY	15,121,615	0	0	90,704	15,212,319	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	283,164,435	4,520,256	13,196,061	8,925,088	283,164,435	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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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	74,462,662					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,615,965	0	21,367,168			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	368,580	0	131,109	1,533,453		8.00
9.00	00900	HOUSEKEEPING	1,798,063	0	394,356	1,628	7,237,108	9.00
10.00	01000	DIETARY	1,248,269	0	782,906	261	271,858	10.00
11.00	01100	CAFETERIA	990,539	0	117,096	0	40,661	11.00
13.00	01300	NURSING ADMINISTRATION	1,428,160	0	600,209	0	208,418	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	523,535	0	588,350	351,140	204,300	14.00
15.00	01500	PHARMACY	1,859,331	0	212,189	7,415	73,681	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	409,559	0	368,546	755	127,974	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	981,989	0	67,630	0	23,484	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,526,831	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	99,793	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,247,480	0	6,340,274	573,682	2,201,606	30.00
31.00	03100	INTENSIVE CARE UNIT	2,417,825	0	314,586	98,765	109,237	31.00
40.00	04000	SUBPROVIDER - IPF	982,747	0	151,582	0	52,635	40.00
41.00	04100	SUBPROVIDER - IRF	634,453	0	258,503	0	89,763	41.00
43.00	04300	NURSERY	344,263	0	57,768	1,788	20,059	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,710,431	0	1,663,871	198,456	577,765	50.00
51.00	05100	RECOVERY ROOM	378,403	0	109,044	3,197	37,865	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,490,981	0	763,026	77,732	264,954	52.00
53.00	05300	ANESTHESIOLOGY	71,947	0	16,041	505	5,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,671,559	0	656,760	3,208	228,054	54.00
54.01	03190	OUTPATIENT ONCOLOGY	697,219	0	7,053	21,722	2,449	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	301,768	0	40,259	232	13,980	55.00
57.00	05700	CT SCAN	330,840	0	67,286	196	23,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	169,381	0	24,780	0	8,605	58.00
59.00	05900	CARDIAC CATHETERIZATION	312,749	0	171,368	45,904	59,506	59.00
60.00	06000	LABORATORY	4,047,011	0	637,130	0	221,238	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	54,692	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	742,325	0	35,328	2,739	12,268	65.00
66.00	06600	PHYSICAL THERAPY	1,186,054	0	278,914	1,283	96,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	377,638	0	30,023	0	10,425	67.00
68.00	06800	SPEECH PATHOLOGY	106,251	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	487,191	0	246,831	618	85,710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,806	0	66,912	0	23,235	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,803,054	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,858,790	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,353,195	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	19,068	0	18,944	6,179	6,578	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,751,606	0	376,691	238	130,803	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	392,825	0	819,202	24	284,461	90.00
91.00	09100	EMERGENCY	4,146,176	0	4,952,601	135,786	1,719,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,027,342	0	21,367,168	1,533,453	7,237,108	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	11,489	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	5,423,831	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 07/01/2020
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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	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	74,462,662	0	21,367,168	1,533,453	7,237,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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From 07/01/2020
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	5,804,338					10.00
11.00	01100	CAFETERIA	0	3,926,480				11.00
13.00	01300	NURSING ADMINISTRATION	0	79,593	6,321,967			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,378	0	3,156,070		14.00
15.00	01500	PHARMACY	0	185,039	0	0	7,552,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,004	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	116,683	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	127,647	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	11,013	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,925,443	1,506,362	3,221,920	1,025,544	2,454,360	30.00
31.00	03100	INTENSIVE CARE UNIT	365,991	183,717	278,219	146,183	349,806	31.00
40.00	04000	SUBPROVIDER - IPF	213,686	61,772	110,667	34,027	81,425	40.00
41.00	04100	SUBPROVIDER - IRF	299,218	63,613	128,383	57,414	137,388	41.00
43.00	04300	NURSERY	0	36,976	64,470	55,716	133,325	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	299,749	287,140	170,690	408,450	50.00
51.00	05100	RECOVERY ROOM	0	39,601	198,618	39,408	94,300	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	178,967	277,785	81,877	195,925	52.00
53.00	05300	ANESTHESIOLOGY	0	5,697	16,471	37,788	90,424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	148,763	311,108	62,050	148,480	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	60,886	62,217	121	289	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	8,130	73,180	794	1,899	55.00
57.00	05700	CT SCAN	0	34,545	0	87,540	209,477	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,999	24,557	14,230	34,052	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,047	42,212	41,252	98,714	59.00
60.00	06000	LABORATORY	0	0	0	351,809	841,853	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	5,899	6,125	3	8	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	17,137	41,007	63.00
65.00	06500	RESPIRATORY THERAPY	0	70,391	135,167	77,799	186,166	65.00
66.00	06600	PHYSICAL THERAPY	0	125,836	325,319	42,276	101,164	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,874	0	20,536	49,140	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,990	0	3,885	9,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0	46,427	98,777	74,446	178,144	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,134	14,595	672	1,609	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	94,825	226,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	63,097	150,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	376,889	901,869	73.00
74.00	07400	RENAL DIALYSIS	0	1,294	1,470	31,734	75,937	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	34,136	69,036	13	30	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	14,940	15,660	0	0	90.00
91.00	09100	EMERGENCY	0	291,351	558,871	146,315	350,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,804,338	3,877,453	6,321,967	3,156,070	7,552,554	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,265	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	42,762	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/30/2021 3:20 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
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)	5,804,338	3,926,480	6,321,967	3,156,070	7,552,554	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
			16.00	17.00	20.00	21.00	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
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	2,073,537					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
20.00	02000	NURSING SCHOOL	0	0	0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		3,943,988		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			5,936,808	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,715,328	0	0	3,566,011	5,367,847	30.00
31.00	03100	INTENSIVE CARE UNIT	123,379	0	0	256,493	386,094	31.00
40.00	04000	SUBPROVIDER - IPF	89,199	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	87,195	0	0	0	0	41.00
43.00	04300	NURSERY	58,436	0	0	121,484	182,867	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,073,537	0	0	3,943,988	5,936,808	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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

 Worksheet B
 Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
						21.00	22.00	
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments			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)	2,073,537	0	0	3,943,988	5,936,808	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
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
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-PHARMACY	390,697				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	94,715,552	-8,933,858	85,781,694	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,811,615	-642,587	11,169,028	31.00
40.00	04000	SUBPROVIDER - IPF	0	4,534,070	0	4,534,070	40.00
41.00	04100	SUBPROVIDER - IRF	0	3,535,391	0	3,535,391	41.00
43.00	04300	NURSERY	0	2,042,713	-304,351	1,738,362	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	21,527,986	0	21,527,986	50.00
51.00	05100	RECOVERY ROOM	0	1,961,751	0	1,961,751	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,513,029	0	7,513,029	52.00
53.00	05300	ANESTHESIOLOGY	0	446,233	0	446,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,918,234	0	7,918,234	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	2,807,458	0	2,807,458	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,286,617	0	1,286,617	55.00
57.00	05700	CT SCAN	0	1,681,163	0	1,681,163	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	764,670	0	764,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,672,925	0	1,672,925	59.00
60.00	06000	LABORATORY	0	17,449,767	0	17,449,767	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	220,124	0	220,124	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	58,144	0	58,144	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,344,196	0	3,344,196	65.00
66.00	06600	PHYSICAL THERAPY	0	5,484,246	0	5,484,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,588,804	0	1,588,804	67.00
68.00	06800	SPEECH PATHOLOGY	0	429,426	0	429,426	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,584,577	0	2,584,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	453,039	0	453,039	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,986,567	0	10,986,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,286,256	0	7,286,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,697	14,427,418	0	14,427,418	73.00
74.00	07400	RENAL DIALYSIS	0	214,683	0	214,683	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	7,275,315	0	7,275,315	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,628,877	0	2,628,877	90.00
91.00	09100	EMERGENCY	0	23,929,828	0	23,929,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	390,697	262,580,674	-9,880,796	252,699,878	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-138,863	0	-138,863	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	CONVENT	0	43,712	0	43,712	194.00
194.01	07951	OUTPATIENT PHARMACY	0	20,678,912	0	20,678,912	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
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Cost Center Description			PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
194.02	07952	FUND DEVELOPMENT	0	0	0	0		194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	390,697	283,164,435	-9,880,796	273,283,639		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

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	35,971	105,012	140,983	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	309,298	902,939	1,212,237	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	631,937	1,844,826	2,476,763	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,740	63,466	85,206	8.00
9.00	00900	HOUSEKEEPING	0	65,391	190,897	256,288	9.00
10.00	01000	DIETARY	0	129,820	378,984	508,804	10.00
11.00	01100	CAFETERIA	0	19,417	56,683	76,100	11.00
13.00	01300	NURSING ADMINISTRATION	0	99,525	290,546	390,071	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,559	284,805	382,364	14.00
15.00	01500	PHARMACY	6,663	35,185	102,715	144,563	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,111	178,403	239,514	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	11,214	32,738	43,952	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,510	1,051,328	3,069,160	4,123,998	30.00
31.00	03100	INTENSIVE CARE UNIT	0	52,164	152,283	204,447	31.00
40.00	04000	SUBPROVIDER - IPF	0	25,135	73,377	98,512	40.00
41.00	04100	SUBPROVIDER - IRF	0	42,864	125,135	167,999	41.00
43.00	04300	NURSERY	0	9,579	27,964	37,543	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	275,899	805,436	1,081,335	50.00
51.00	05100	RECOVERY ROOM	0	18,081	52,785	70,866	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	126,523	369,361	495,884	52.00
53.00	05300	ANESTHESIOLOGY	0	2,660	7,765	10,425	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	108,902	317,920	426,822	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	1,170	3,414	4,584	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,676	19,489	26,165	55.00
57.00	05700	CT SCAN	0	11,157	32,572	43,729	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,109	11,995	16,104	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	28,416	82,955	111,371	59.00
60.00	06000	LABORATORY	0	105,647	308,418	414,065	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	5,858	17,102	22,960	65.00
66.00	06600	PHYSICAL THERAPY	0	46,249	135,015	181,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,978	14,533	19,511	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,929	119,484	160,413	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,095	32,390	43,485	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,141	9,170	12,311	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	62,462	182,346	244,808	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	76.01
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	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	19,493	135,838	396,554	551,885	90.00
91.00	09100	EMERGENCY	17,979	821,228	2,397,424	3,236,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,645	4,520,256	13,196,061	17,763,962	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

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
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	1,432 194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0 194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0 194.03
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	47,645	4,520,256	13,196,061	17,763,962	140,983 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,221,349					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	92,113	0	2,568,876			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,045	0	15,763	107,014		8.00
9.00	00900	HOUSEKEEPING	29,492	0	47,412	114	333,306	9.00
10.00	01000	DIETARY	20,474	0	94,125	18	12,520	10.00
11.00	01100	CAFETERIA	16,247	0	14,078	0	1,873	11.00
13.00	01300	NURSING ADMINISTRATION	23,425	0	72,160	0	9,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,587	0	70,735	24,505	9,409	14.00
15.00	01500	PHARMACY	30,497	0	25,511	517	3,393	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,718	0	44,309	53	5,894	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	16,107	0	8,131		1,082	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	25,043	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	1,637	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	266,500	0	762,258	40,034	101,395	30.00
31.00	03100	INTENSIVE CARE UNIT	39,657	0	37,821	6,892	5,031	31.00
40.00	04000	SUBPROVIDER - IPF	16,119	0	18,224	0	2,424	40.00
41.00	04100	SUBPROVIDER - IRF	10,406	0	31,079	0	4,134	41.00
43.00	04300	NURSERY	5,647	0	6,945	125	924	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	77,260	0	200,040	13,850	26,609	50.00
51.00	05100	RECOVERY ROOM	6,207	0	13,110	223	1,744	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,455	0	91,735	5,425	12,203	52.00
53.00	05300	ANESTHESIOLOGY	1,180	0	1,929	35	257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,417	0	78,959	224	10,503	54.00
54.01	03190	OUTPATIENT ONCOLOGY	11,436	0	848	1,516	113	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	4,950	0	4,840	16	644	55.00
57.00	05700	CT SCAN	5,426	0	8,090	14	1,076	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,778	0	2,979	0	396	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,130	0	20,603	3,203	2,741	59.00
60.00	06000	LABORATORY	66,379	0	76,599	0	10,189	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	897	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	12,176	0	4,247	191	565	65.00
66.00	06600	PHYSICAL THERAPY	19,454	0	33,533	90	4,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,194	0	3,610	0	480	67.00
68.00	06800	SPEECH PATHOLOGY	1,743	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,991	0	29,675	43	3,947	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,457	0	8,045	0	1,070	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,976	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,488	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,999	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	313	0	2,278	431	303	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	28,730	0	45,288	17	6,024	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,443	0	98,489	2	13,101	90.00
91.00	09100	EMERGENCY	68,006	0	595,428	9,476	79,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,132,199	0	2,568,876	107,014	333,306	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	188	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	88,962	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,221,349	0	2,568,876	107,014	333,306	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	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	636,083					10.00
11.00	01100	CAFETERIA	0	108,464				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,199	500,120			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	563	0	496,846		14.00
15.00	01500	PHARMACY	0	5,112	0	0	215,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	497	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	3,224	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,527	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	304	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	539,767	41,598	254,882	161,523	70,220	30.00
31.00	03100	INTENSIVE CARE UNIT	40,108	5,076	22,009	23,008	9,988	31.00
40.00	04000	SUBPROVIDER - IPF	23,417	1,707	8,755	5,356	2,325	40.00
41.00	04100	SUBPROVIDER - IRF	32,791	1,758	10,156	9,036	3,923	41.00
43.00	04300	NURSERY	0	1,022	5,100	8,769	3,807	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,282	22,715	26,865	11,663	50.00
51.00	05100	RECOVERY ROOM	0	1,094	15,712	6,202	2,693	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,945	21,975	12,887	5,594	52.00
53.00	05300	ANESTHESIOLOGY	0	157	1,303	5,947	2,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,110	24,611	9,766	4,240	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	1,682	4,922	19	8	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	225	5,789	125	54	55.00
57.00	05700	CT SCAN	0	954	0	13,778	5,981	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	387	1,943	2,240	972	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	664	3,339	6,493	2,819	59.00
60.00	06000	LABORATORY	0	0	0	55,371	24,038	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	163	485	1	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,697	1,171	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,945	10,693	12,245	5,316	65.00
66.00	06600	PHYSICAL THERAPY	0	3,477	25,735	6,654	2,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,157	0	3,232	1,403	67.00
68.00	06800	SPEECH PATHOLOGY	0	331	0	611	265	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,283	7,814	11,717	5,087	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	225	1,155	106	46	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,924	6,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,931	4,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,318	25,751	73.00
74.00	07400	RENAL DIALYSIS	0	36	116	4,995	2,168	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	943	5,461	2	1	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	413	1,239	0	0	90.00
91.00	09100	EMERGENCY	0	8,050	44,211	23,028	9,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	636,083	107,110	500,120	496,846	215,791	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	173	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	1,181	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
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)	636,083	108,464	500,120	496,846	215,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			INTERNS & RESIDENTS					
			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	SERVICES-SALAR		SERVICES-OTHER
						Y & FRINGES APPRV		PRGM COSTS APPRV
			16.00	17.00	20.00	21.00	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
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	297,588					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
20.00	02000	NURSING SCHOOL	0	0	0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		76,404		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			32,846	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	246,178	0				30.00
31.00	03100	INTENSIVE CARE UNIT	17,707	0				31.00
40.00	04000	SUBPROVIDER - IPF	12,802	0				40.00
41.00	04100	SUBPROVIDER - IRF	12,514	0				41.00
43.00	04300	NURSERY	8,387	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0				50.00
51.00	05100	RECOVERY ROOM	0	0				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0				54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0				55.00
57.00	05700	CT SCAN	0	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0				59.00
60.00	06000	LABORATORY	0	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
65.00	06500	RESPIRATORY THERAPY	0	0				65.00
66.00	06600	PHYSICAL THERAPY	0	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0				67.00
68.00	06800	SPEECH PATHOLOGY	0	0				68.00
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00	07400	RENAL DIALYSIS	0	0				74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0				75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0				76.00
76.01	03950	IP RENAL DIALYSIS	0	0				76.01
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0				90.00
91.00	09100	EMERGENCY	0	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	297,588	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
193.00	19300	NONPAID WORKERS	0	0				193.00
194.00	07950	CONVENT	0	0				194.00
194.01	07951	OUTPATIENT PHARMACY	0	0				194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

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

 Worksheet B
 Part II
 Date/Time Prepared:
 11/30/2021 3:20 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
						21.00	22.00	
194.02	07952	FUND DEVELOPMENT	0	0				194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0				194.03
200.00		Cross Foot Adjustments			0	76,404	32,846	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	297,588	0	0	76,404	32,846	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
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
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-PHARMACY	2,310				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		6,658,853	0	6,658,853	30.00
31.00	03100	INTENSIVE CARE UNIT		417,898	0	417,898	31.00
40.00	04000	SUBPROVIDER - IPF		191,710	0	191,710	40.00
41.00	04100	SUBPROVIDER - IRF		285,927	0	285,927	41.00
43.00	04300	NURSERY		79,508	0	79,508	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		1,478,659	0	1,478,659	50.00
51.00	05100	RECOVERY ROOM		119,177	0	119,177	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		681,098	0	681,098	52.00
53.00	05300	ANESTHESIOLOGY		24,006	0	24,006	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		591,635	0	591,635	54.00
54.01	03190	OUTPATIENT ONCOLOGY		27,167	0	27,167	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		43,080	0	43,080	55.00
57.00	05700	CT SCAN		80,205	0	80,205	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		28,268	0	28,268	58.00
59.00	05900	CARDIAC CATHETERIZATION		157,168	0	157,168	59.00
60.00	06000	LABORATORY		646,641	0	646,641	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		1,744	0	1,744	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		3,868	0	3,868	63.00
65.00	06500	RESPIRATORY THERAPY		72,696	0	72,696	65.00
66.00	06600	PHYSICAL THERAPY		281,771	0	281,771	66.00
67.00	06700	OCCUPATIONAL THERAPY		36,990	0	36,990	67.00
68.00	06800	SPEECH PATHOLOGY		3,352	0	3,352	68.00
69.00	06900	ELECTROCARDIOLOGY		229,525	0	229,525	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		55,861	0	55,861	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		67,379	0	67,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		44,730	0	44,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		140,068	0	140,068	73.00
74.00	07400	RENAL DIALYSIS		22,994	0	22,994	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		332,417	0	332,417	76.00
76.01	03950	IP RENAL DIALYSIS		0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		672,072	0	672,072	90.00
91.00	09100	EMERGENCY		4,083,789	0	4,083,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,560,256	0	17,560,256	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		383	0	383	192.00
193.00	19300	NONPAID WORKERS		0	0	0	193.00
194.00	07950	CONVENT		188	0	188	194.00
194.01	07951	OUTPATIENT PHARMACY		91,575	0	91,575	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
194.02	07952	FUND DEVELOPMENT		0	0	0		194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE		0	0	0		194.03
200.00		Cross Foot Adjustments	2,310	111,560	0	111,560		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,310	17,763,962	0	17,763,962		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	873,483					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		873,483				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,951	6,951	88,809,278			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	59,768	59,768	5,741,397	-74,462,662	208,846,901	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	122,114	122,114	0	0	15,751,203	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,201	4,201	0	0	1,033,764	8.00
9.00	00900	HOUSEKEEPING	12,636	12,636	0	0	5,043,061	9.00
10.00	01000	DIETARY	25,086	25,086	89,504	0	3,501,044	10.00
11.00	01100	CAFETERIA	3,752	3,752	104,501	0	2,778,184	11.00
13.00	01300	NURSING ADMINISTRATION	19,232	19,232	1,679,925	0	4,005,587	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,852	18,852	430,115	0	1,468,367	14.00
15.00	01500	PHARMACY	6,799	6,799	3,905,505	0	5,214,899	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,809	11,809	380,005	0	1,148,699	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,167	2,167	2,462,751	0	2,754,202	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	2,694,160	0	4,282,330	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	0	232,444	0	279,891	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	203,156	203,156	31,793,937	0	45,569,695	30.00
31.00	03100	INTENSIVE CARE UNIT	10,080	10,080	3,877,598	0	6,781,320	31.00
40.00	04000	SUBPROVIDER - IPF	4,857	4,857	1,303,775	0	2,756,330	40.00
41.00	04100	SUBPROVIDER - IRF	8,283	8,283	1,342,638	0	1,779,461	41.00
43.00	04300	NURSERY	1,851	1,851	780,421	0	965,561	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,314	53,314	6,326,622	0	13,211,434	50.00
51.00	05100	RECOVERY ROOM	3,494	3,494	835,826	0	1,061,315	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,449	24,449	3,777,353	0	4,181,782	52.00
53.00	05300	ANESTHESIOLOGY	514	514	120,244	0	201,790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,044	21,044	3,139,846	0	4,688,252	54.00
54.01	03190	OUTPATIENT ONCOLOGY	226	226	1,285,082	0	1,955,502	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,290	1,290	171,590	0	846,375	55.00
57.00	05700	CT SCAN	2,156	2,156	729,128	0	927,914	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	794	794	295,478	0	475,066	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,491	5,491	507,545	0	877,173	59.00
60.00	06000	LABORATORY	20,415	20,415	0	0	11,350,726	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	124,504	0	153,397	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,132	1,132	1,485,693	0	2,082,013	65.00
66.00	06600	PHYSICAL THERAPY	8,937	8,937	2,655,936	0	3,326,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	962	962	883,802	0	1,059,168	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	253,075	0	298,003	68.00
69.00	06900	ELECTROCARDIOLOGY	7,909	7,909	979,907	0	1,366,433	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,144	2,144	171,674	0	249,076	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,861,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,213,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,404,768	73.00
74.00	07400	RENAL DIALYSIS	607	607	27,322	0	53,479	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12,070	12,070	720,494	0	4,912,762	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	26,249	26,249	315,330	0	1,101,765	90.00
91.00	09100	EMERGENCY	158,692	158,692	6,149,363	0	11,628,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	873,483	873,483	87,774,490	-74,462,662	193,602,359	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	132,232	145,128	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
194.00	07950	CONVENT	0	0	0	0	32,223	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	902,556	0	15,212,319	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,520,256	13,196,061	8,925,088		74,462,662	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.174979	15.107404	0.100497		0.356542	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			140,983		1,221,349	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001587		0.005848	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: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	684,650				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,201	258,094			8.00
9.00	00900	HOUSEKEEPING	0	12,636	274	667,813		9.00
10.00	01000	DIETARY	0	25,086	44	25,086	101,182	10.00
11.00	01100	CAFETERIA	0	3,752	0	3,752	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,232	0	19,232	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,852	59,100	18,852	0	14.00
15.00	01500	PHARMACY	0	6,799	1,248	6,799	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,809	127	11,809	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	2,167	0	2,167	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-PHARMACY	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	203,156	96,556	203,156	85,861	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,080	16,623	10,080	6,380	31.00
40.00	04000	SUBPROVIDER - IPF	0	4,857	0	4,857	3,725	40.00
41.00	04100	SUBPROVIDER - IRF	0	8,283	0	8,283	5,216	41.00
43.00	04300	NURSERY	0	1,851	301	1,851	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	53,314	33,402	53,314	0	50.00
51.00	05100	RECOVERY ROOM	0	3,494	538	3,494	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,449	13,083	24,449	0	52.00
53.00	05300	ANESTHESIOLOGY	0	514	85	514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,044	540	21,044	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	226	3,656	226	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,290	39	1,290	0	55.00
57.00	05700	CT SCAN	0	2,156	33	2,156	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	794	0	794	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,491	7,726	5,491	0	59.00
60.00	06000	LABORATORY	0	20,415	0	20,415	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,132	461	1,132	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,937	216	8,937	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	962	0	962	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,909	104	7,909	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,144	0	2,144	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	607	1,040	607	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	12,070	40	12,070	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	26,249	4	26,249	0	90.00
91.00	09100	EMERGENCY	0	158,692	22,854	158,692	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	684,650	258,094	667,813	101,182	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			6.00	7.00	8.00	9.00	10.00	
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	21,367,168	1,533,453	7,237,108	5,804,338	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	31.208892	5.941452	10.837028	57.365322	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,568,876	107,014	333,306	636,083	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.752101	0.414632	0.499101	6.286523	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: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING HO URS)	CENTRAL SERVICES & SUPPLY (INPATIENT REVENUE)	PHARMACY (INPATIENT REVENUE)	MEDICAL RECORDS & LIBRARY (PATIENT DA YS)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	82,873,876					11.00
13.00	01300	NURSING ADMINISTRATION	1,679,925	1,792,844				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	430,115	0	688,952,617			14.00
15.00	01500	PHARMACY	3,905,505	0	0	688,952,617		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380,005	0	0	0	87,964	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,462,751	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,694,160	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	232,444	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,793,937	913,703	223,873,615	223,873,615	72,768	30.00
31.00	03100	INTENSIVE CARE UNIT	3,877,598	78,900	31,910,783	31,910,783	5,234	31.00
40.00	04000	SUBPROVIDER - IPF	1,303,775	31,384	7,427,949	7,427,949	3,784	40.00
41.00	04100	SUBPROVIDER - IRF	1,342,638	36,408	12,533,157	12,533,157	3,699	41.00
43.00	04300	NURSERY	780,421	18,283	12,162,491	12,162,491	2,479	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,326,622	81,430	37,260,528	37,260,528	0	50.00
51.00	05100	RECOVERY ROOM	835,826	56,326	8,602,458	8,602,458	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,777,353	78,777	17,873,151	17,873,151	0	52.00
53.00	05300	ANESTHESIOLOGY	120,244	4,671	8,248,849	8,248,849	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,139,846	88,227	13,544,992	13,544,992	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	1,285,082	17,644	26,345	26,345	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	171,590	20,753	173,249	173,249	0	55.00
57.00	05700	CT SCAN	729,128	0	19,109,336	19,109,336	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,478	6,964	3,106,350	3,106,350	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	507,545	11,971	9,005,121	9,005,121	0	59.00
60.00	06000	LABORATORY	0	0	76,797,380	76,797,380	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	124,504	1,737	726	726	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	3,740,868	3,740,868	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,485,693	38,332	16,982,882	16,982,882	0	65.00
66.00	06600	PHYSICAL THERAPY	2,655,936	92,257	9,228,639	9,228,639	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	883,802	0	4,482,771	4,482,771	0	67.00
68.00	06800	SPEECH PATHOLOGY	253,075	0	848,096	848,096	0	68.00
69.00	06900	ELECTROCARDIOLOGY	979,907	28,012	16,251,072	16,251,072	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	171,674	4,139	146,782	146,782	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,699,593	20,699,593	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,773,604	13,773,604	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	82,272,292	82,272,292	0	73.00
74.00	07400	RENAL DIALYSIS	27,322	417	6,927,276	6,927,276	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	720,494	19,578	2,731	2,731	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	315,330	4,441	0	0	0	90.00
91.00	09100	EMERGENCY	6,149,363	158,490	31,939,531	31,939,531	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,839,088	1,792,844	688,952,617	688,952,617	87,964	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	132,232	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	902,556	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING HO URS)	CENTRAL SERVICES & SUPPLY (INPATIENT REVENUE)	PHARMACY (INPATIENT REVENUE)	MEDICAL RECORDS & LIBRARY (PATIENT DA YS)	
			11.00	13.00	14.00	15.00	16.00	
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,926,480	6,321,967	3,156,070	7,552,554	2,073,537	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.047379	3.526223	0.004581	0.010962	23.572564	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,464	500,120	496,846	215,791	297,588	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001309	0.278953	0.000721	0.000313	3.383066	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: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			INTERNS & RESIDENTS				PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			SOCIAL SERVICE	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER		
			(DAYS)	(PATIENT DA YS)	APPRV (PATIENT DA YS)	PRGM COSTS APPRV (PATIENT DA YS)		
			17.00	20.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	0					17.00
20.00	02000	NURSING SCHOOL	0	0				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0		80,481			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			80,481		22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0				100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	72,768	72,768	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,234	5,234	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	2,479	2,479	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	80,481	80,481	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			SOCIAL SERVICE (DAYS)	NURSING SCHOOL (PATIENT DAYS)	INTERNS & RESIDENTS		PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
					SERVICES-SALAR Y & FRINGES APPRV (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS APPRV (PATIENT DAYS)		
					21.00	22.00		
194.00	07950	CONVENT	0	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	3,943,988	5,936,808	390,697	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	49.005206	73.766578	3,906.970000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	76,404	32,846	2,310	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.949342	0.408121	23.100000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0			0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	85,781,694		85,781,694		0	85,781,694	30.00
31.00	03100	INTENSIVE CARE UNIT	11,169,028		11,169,028		0	11,169,028	31.00
40.00	04000	SUBPROVIDER - IPF	4,534,070		4,534,070		0	4,534,070	40.00
41.00	04100	SUBPROVIDER - IRF	3,535,391		3,535,391	12,663		3,548,054	41.00
43.00	04300	NURSERY	1,738,362		1,738,362		0	1,738,362	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		0	0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	21,527,986		21,527,986	165,080		21,693,066	50.00
51.00	05100	RECOVERY ROOM	1,961,751		1,961,751		0	1,961,751	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,513,029		7,513,029		0	7,513,029	52.00
53.00	05300	ANESTHESIOLOGY	446,233		446,233		0	446,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,918,234		7,918,234		0	7,918,234	54.00
54.01	03190	OUTPATIENT ONCOLOGY	2,807,458		2,807,458		0	2,807,458	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,286,617		1,286,617		0	1,286,617	55.00
57.00	05700	CT SCAN	1,681,163		1,681,163		0	1,681,163	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	764,670		764,670		0	764,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,672,925		1,672,925		0	1,672,925	59.00
60.00	06000	LABORATORY	17,449,767		17,449,767		0	17,449,767	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	220,124		220,124		0	220,124	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	58,144		58,144		0	58,144	63.00
65.00	06500	RESPIRATORY THERAPY	3,344,196	0	3,344,196		0	3,344,196	65.00
66.00	06600	PHYSICAL THERAPY	5,484,246	0	5,484,246		0	5,484,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,588,804	0	1,588,804		0	1,588,804	67.00
68.00	06800	SPEECH PATHOLOGY	429,426	0	429,426		0	429,426	68.00
69.00	06900	ELECTROCARDIOLOGY	2,584,577		2,584,577		0	2,584,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	453,039		453,039	574		453,613	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,986,567		10,986,567		0	10,986,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,286,256		7,286,256		0	7,286,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,427,418		14,427,418		0	14,427,418	73.00
74.00	07400	RENAL DIALYSIS	214,683		214,683		0	214,683	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0		0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,275,315		7,275,315		0	7,275,315	76.00
76.01	03950	IP RENAL DIALYSIS	0		0		0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0		0		0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0		0	0	76.98
76.99	07699	LITHOTRIPSY	0		0		0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	2,628,877		2,628,877		0	2,628,877	90.00
91.00	09100	EMERGENCY	23,929,828		23,929,828	12,663		23,942,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,438,239		3,438,239			3,438,239	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	256,138,117	0	256,138,117	190,980		256,329,097	200.00
201.00		Less Observation Beds	3,438,239		3,438,239			3,438,239	201.00
202.00		Total (see instructions)	252,699,878	0	252,699,878	190,980		252,890,858	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:20 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	221,206,267		221,206,267			30.00
31.00	03100	INTENSIVE CARE UNIT	31,910,783		31,910,783			31.00
40.00	04000	SUBPROVIDER - IPF	7,427,949		7,427,949			40.00
41.00	04100	SUBPROVIDER - IRF	12,533,157		12,533,157			41.00
43.00	04300	NURSERY	12,162,491		12,162,491			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,260,528	94,339,920	131,600,448	0.163586	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,602,458	14,177,680	22,780,138	0.086117	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,873,151	1,686,272	19,559,423	0.384113	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,248,849	20,048,654	28,297,503	0.015769	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,544,992	63,281,403	76,826,395	0.103067	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	26,345	84,787,370	84,813,715	0.033101	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	173,249	7,977,626	8,150,875	0.157850	0.000000	55.00
57.00	05700	CT SCAN	19,109,336	35,288,766	54,398,102	0.030905	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,106,350	11,742,027	14,848,377	0.051499	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,005,121	3,067,892	12,073,013	0.138567	0.000000	59.00
60.00	06000	LABORATORY	76,797,380	64,988,454	141,785,834	0.123071	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	726	344,761	345,487	0.637141	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,740,868	1,024,358	4,765,226	0.012202	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	16,982,882	1,544,431	18,527,313	0.180501	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,228,639	17,992,936	27,221,575	0.201467	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,482,771	2,996,000	7,478,771	0.212442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	848,096	45,187	893,283	0.480728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,251,072	24,668,099	40,919,171	0.063163	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,782	1,583,827	1,730,609	0.261780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,699,593	19,470,093	40,169,686	0.273504	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,773,604	18,376,126	32,149,730	0.226635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,272,292	52,710,582	134,982,874	0.106883	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,927,276	397,643	7,324,919	0.029309	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,731	10,663,067	10,665,798	0.682116	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0.000000	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,014,244	3,014,244	0.872151	0.000000	90.00
91.00	09100	EMERGENCY	31,939,531	83,900,877	115,840,408	0.206576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,667,348	13,783,406	16,450,754	0.209002	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	688,952,617	653,901,701	1,342,854,318			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	688,952,617	653,901,701	1,342,854,318			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:20 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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.164840		50.00
51.00	05100	RECOVERY ROOM	0.086117		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384113		52.00
53.00	05300	ANESTHESIOLOGY	0.015769		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103067		54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.033101		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.157850		55.00
57.00	05700	CT SCAN	0.030905		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051499		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138567		59.00
60.00	06000	LABORATORY	0.123071		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.637141		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.012202		63.00
65.00	06500	RESPIRATORY THERAPY	0.180501		65.00
66.00	06600	PHYSICAL THERAPY	0.201467		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212442		67.00
68.00	06800	SPEECH PATHOLOGY	0.480728		68.00
69.00	06900	ELECTROCARDIOLOGY	0.063163		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.262112		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226635		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.106883		73.00
74.00	07400	RENAL DIALYSIS	0.029309		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116		76.00
76.01	03950	IP RENAL DIALYSIS	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.872151		90.00
91.00	09100	EMERGENCY	0.206685		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.209002		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

			Title XIX		Hospital		Cost	
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	85,781,694		85,781,694	0	85,781,694	30.00
31.00	03100	INTENSIVE CARE UNIT	11,169,028		11,169,028	0	11,169,028	31.00
40.00	04000	SUBPROVIDER - IPF	4,534,070		4,534,070	0	4,534,070	40.00
41.00	04100	SUBPROVIDER - IRF	3,535,391		3,535,391	12,663	3,548,054	41.00
43.00	04300	NURSERY	1,738,362		1,738,362	0	1,738,362	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,527,986		21,527,986	165,080	21,693,066	50.00
51.00	05100	RECOVERY ROOM	1,961,751		1,961,751	0	1,961,751	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,513,029		7,513,029	0	7,513,029	52.00
53.00	05300	ANESTHESIOLOGY	446,233		446,233	0	446,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,918,234		7,918,234	0	7,918,234	54.00
54.01	03190	OUTPATIENT ONCOLOGY	2,807,458		2,807,458	0	2,807,458	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,286,617		1,286,617	0	1,286,617	55.00
57.00	05700	CT SCAN	1,681,163		1,681,163	0	1,681,163	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	764,670		764,670	0	764,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,672,925		1,672,925	0	1,672,925	59.00
60.00	06000	LABORATORY	17,449,767		17,449,767	0	17,449,767	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	220,124		220,124	0	220,124	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	58,144		58,144	0	58,144	63.00
65.00	06500	RESPIRATORY THERAPY	3,344,196	0	3,344,196	0	3,344,196	65.00
66.00	06600	PHYSICAL THERAPY	5,484,246	0	5,484,246	0	5,484,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,588,804	0	1,588,804	0	1,588,804	67.00
68.00	06800	SPEECH PATHOLOGY	429,426	0	429,426	0	429,426	68.00
69.00	06900	ELECTROCARDIOLOGY	2,584,577		2,584,577	0	2,584,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	453,039		453,039	574	453,613	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,986,567		10,986,567	0	10,986,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,286,256		7,286,256	0	7,286,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,427,418		14,427,418	0	14,427,418	73.00
74.00	07400	RENAL DIALYSIS	214,683		214,683	0	214,683	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,275,315		7,275,315	0	7,275,315	76.00
76.01	03950	IP RENAL DIALYSIS	0		0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,628,877		2,628,877	0	2,628,877	90.00
91.00	09100	EMERGENCY	23,929,828		23,929,828	12,663	23,942,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,438,239		3,438,239		3,438,239	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	256,138,117	0	256,138,117	190,980	256,329,097	200.00
201.00		Less Observation Beds	3,438,239		3,438,239		3,438,239	201.00
202.00		Total (see instructions)	252,699,878	0	252,699,878	190,980	252,890,858	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 3:20 pm	
					Title XIX		Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	221,206,267		221,206,267			30.00
31.00	03100	INTENSIVE CARE UNIT	31,910,783		31,910,783			31.00
40.00	04000	SUBPROVIDER - IPF	7,427,949		7,427,949			40.00
41.00	04100	SUBPROVIDER - IRF	12,533,157		12,533,157			41.00
43.00	04300	NURSERY	12,162,491		12,162,491			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,260,528	94,339,920	131,600,448	0.163586	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,602,458	14,177,680	22,780,138	0.086117	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,873,151	1,686,272	19,559,423	0.384113	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,248,849	20,048,654	28,297,503	0.015769	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,544,992	63,281,403	76,826,395	0.103067	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	26,345	84,787,370	84,813,715	0.033101	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	173,249	7,977,626	8,150,875	0.157850	0.000000	55.00
57.00	05700	CT SCAN	19,109,336	35,288,766	54,398,102	0.030905	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,106,350	11,742,027	14,848,377	0.051499	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,005,121	3,067,892	12,073,013	0.138567	0.000000	59.00
60.00	06000	LABORATORY	76,797,380	64,988,454	141,785,834	0.123071	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	726	344,761	345,487	0.637141	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,740,868	1,024,358	4,765,226	0.012202	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	16,982,882	1,544,431	18,527,313	0.180501	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,228,639	17,992,936	27,221,575	0.201467	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,482,771	2,996,000	7,478,771	0.212442	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	848,096	45,187	893,283	0.480728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	16,251,072	24,668,099	40,919,171	0.063163	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	146,782	1,583,827	1,730,609	0.261780	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,699,593	19,470,093	40,169,686	0.273504	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,773,604	18,376,126	32,149,730	0.226635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,272,292	52,710,582	134,982,874	0.106883	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,927,276	397,643	7,324,919	0.029309	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,731	10,663,067	10,665,798	0.682116	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0.000000	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,014,244	3,014,244	0.872151	0.000000	90.00
91.00	09100	EMERGENCY	31,939,531	83,900,877	115,840,408	0.206576	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,667,348	13,783,406	16,450,754	0.209002	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	688,952,617	653,901,701	1,342,854,318			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	688,952,617	653,901,701	1,342,854,318			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 3:20 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
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03950	IP RENAL DIALYSIS	0.000000			76.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/30/2021 3:20 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,658,853	0	6,658,853	70,981	93.81	30.00
31.00	INTENSIVE CARE UNIT	417,898		417,898	5,104	81.88	31.00
40.00	SUBPROVIDER - IPF	191,710	0	191,710	2,980	64.33	40.00
41.00	SUBPROVIDER - IRF	285,927	0	285,927	4,173	68.52	41.00
43.00	NURSERY	79,508		79,508	2,076	38.30	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	7,633,896		7,633,896	85,314		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	15,328	1,437,920				30.00
31.00	INTENSIVE CARE UNIT	1,074	87,939				31.00
40.00	SUBPROVIDER - IPF	450	28,949				40.00
41.00	SUBPROVIDER - IRF	1,316	90,172				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	18,168	1,644,980				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,478,659	131,600,448	0.011236	9,393,987	105,551	50.00
51.00	05100 RECOVERY ROOM	119,177	22,780,138	0.005232	1,826,792	9,558	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	681,098	19,559,423	0.034822	56,280	1,960	52.00
53.00	05300 ANESTHESIOLOGY	24,006	28,297,503	0.000848	1,948,651	1,652	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	591,635	76,826,395	0.007701	4,144,252	31,915	54.00
54.01	03190 OUTPATIENT ONCOLOGY	27,167	84,813,715	0.000320	5,275	2	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	43,080	8,150,875	0.005285	8,185	43	55.00
57.00	05700 CT SCAN	80,205	54,398,102	0.001474	5,260,697	7,754	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	28,268	14,848,377	0.001904	824,922	1,571	58.00
59.00	05900 CARDIAC CATHETERIZATION	157,168	12,073,013	0.013018	2,102,572	27,371	59.00
60.00	06000 LABORATORY	646,641	141,785,834	0.004561	19,338,822	88,204	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1,744	345,487	0.005048	202	1	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3,868	4,765,226	0.000812	942,285	765	63.00
65.00	06500 RESPIRATORY THERAPY	72,696	18,527,313	0.003924	5,328,171	20,908	65.00
66.00	06600 PHYSICAL THERAPY	281,771	27,221,575	0.010351	1,312,420	13,585	66.00
67.00	06700 OCCUPATIONAL THERAPY	36,990	7,478,771	0.004946	559,365	2,767	67.00
68.00	06800 SPEECH PATHOLOGY	3,352	893,283	0.003752	201,296	755	68.00
69.00	06900 ELECTROCARDIOLOGY	229,525	40,919,171	0.005609	4,958,224	27,811	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	55,861	1,730,609	0.032278	37,719	1,217	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	67,379	40,169,686	0.001677	5,320,445	8,922	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	44,730	32,149,730	0.001391	3,777,621	5,255	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	140,068	134,982,874	0.001038	20,673,328	21,459	73.00
74.00	07400 RENAL DIALYSIS	22,994	7,324,919	0.003139	2,670,957	8,384	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	332,417	10,665,798	0.031167	992	31	76.00
76.01	03950 IP RENAL DIALYSIS	0	0	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	672,072	3,014,244	0.222965	0	0	90.00
91.00	09100 EMERGENCY	4,083,789	115,840,408	0.035254	7,846,973	276,637	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	266,897	16,450,754	0.016224	622,881	10,106	92.00
200.00	Total (lines 50 through 199)	10,193,257	1,057,613,671		99,163,314	674,184	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/30/2021 3:20 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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)		Inpatient Program Days			
			4.00	5.00	6.00	7.00		8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	70,981	0.00	15,328		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	5,104	0.00	1,074		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	2,980	0.00	450		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	4,173	0.00	1,316		41.00		
43.00	04300	NURSERY		0	2,076	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)		0	85,314		18,168		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	390,697	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	390,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 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	131,600,448	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	22,780,138	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,559,423	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,297,503	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	76,826,395	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	84,813,715	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,150,875	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	54,398,102	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,848,377	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,073,013	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	141,785,834	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	345,487	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,765,226	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,527,313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,221,575	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,478,771	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	893,283	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,919,171	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,730,609	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,169,686	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,149,730	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	390,697	390,697	134,982,874	0.002894	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,324,919	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	10,665,798	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,014,244	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	115,840,408	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,450,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	390,697	390,697	1,057,613,671		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Hospital		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		9,393,987	0	13,159,699	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		1,826,792	0	1,488,285	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		56,280	0	3,062	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		1,948,651	0	2,839,682	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		4,144,252	0	6,960,198	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.000000		5,275	0	4,131,569	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		8,185	0	1,901,238	0	55.00
57.00	05700	CT SCAN	0.000000		5,260,697	0	5,579,012	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		824,922	0	1,796,270	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		2,102,572	0	1,317,457	0	59.00
60.00	06000	LABORATORY	0.000000		19,338,822	0	6,568,006	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		202	0	71,291	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		942,285	0	192,040	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		5,328,171	0	172,127	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		1,312,420	0	33,073	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		559,365	0	13,266	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		201,296	0	1,819	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		4,958,224	0	4,130,979	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		37,719	0	175,959	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		5,320,445	0	2,759,507	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		3,777,621	0	2,609,899	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002894		20,673,328	59,829	36,591,379	105,895	73.00
74.00	07400	RENAL DIALYSIS	0.000000		2,670,957	0	145,432	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		992	0	1,435,030	0	76.00
76.01	03950	IP RENAL DIALYSIS	0.000000		0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		0	0	556,814	0	90.00
91.00	09100	EMERGENCY	0.000000		7,846,973	0	7,196,377	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		622,881	0	1,037,900	0	92.00
200.00		Total (lines 50 through 199)			99,163,314	59,829	102,867,370	105,895	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 3:20 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	0.163586	13,159,699	0	0	2,152,743	50.00
51.00	05100	RECOVERY ROOM	0.086117	1,488,285	0	0	128,167	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384113	3,062	0	0	1,176	52.00
53.00	05300	ANESTHESIOLOGY	0.015769	2,839,682	0	0	44,779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103067	6,960,198	0	0	717,367	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.033101	4,131,569	0	71	136,759	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.157850	1,901,238	0	0	300,110	55.00
57.00	05700	CT SCAN	0.030905	5,579,012	0	0	172,419	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051499	1,796,270	0	0	92,506	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138567	1,317,457	0	0	182,556	59.00
60.00	06000	LABORATORY	0.123071	6,568,006	5,211	0	808,331	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.637141	71,291	0	0	45,422	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.012202	192,040	7	0	2,343	63.00
65.00	06500	RESPIRATORY THERAPY	0.180501	172,127	0	0	31,069	65.00
66.00	06600	PHYSICAL THERAPY	0.201467	33,073	0	0	6,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212442	13,266	0	0	2,818	67.00
68.00	06800	SPEECH PATHOLOGY	0.480728	1,819	0	0	874	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063163	4,130,979	0	0	260,925	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.261780	175,959	0	0	46,063	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504	2,759,507	0	0	754,736	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226635	2,609,899	0	0	591,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.106883	36,591,379	3	112,808	3,910,996	73.00
74.00	07400	RENAL DIALYSIS	0.029309	145,432	0	0	4,262	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116	1,435,030	0	0	978,857	76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.872151	556,814	0	0	485,626	90.00
91.00	09100	EMERGENCY	0.206576	7,196,377	0	5	1,486,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209002	1,037,900	0	1	216,923	92.00
200.00		Subtotal (see instructions)		102,867,370	5,221	112,885	13,562,583	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		102,867,370	5,221	112,885	13,562,583	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 3:20 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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	2		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	641	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,057		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03950	IP RENAL DIALYSIS	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	1		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	641	12,060		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	641	12,060		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0180

Period:

Worksheet D

Component CCN: 14-S180

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
11/30/2021 3:20 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	1,478,659	131,600,448	0.011236	0	0	50.00
51.00	05100 RECOVERY ROOM	119,177	22,780,138	0.005232	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	681,098	19,559,423	0.034822	0	0	52.00
53.00	05300 ANESTHESIOLOGY	24,006	28,297,503	0.000848	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	591,635	76,826,395	0.007701	0	0	54.00
54.01	03190 OUTPATIENT ONCOLOGY	27,167	84,813,715	0.000320	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	43,080	8,150,875	0.005285	0	0	55.00
57.00	05700 CT SCAN	80,205	54,398,102	0.001474	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	28,268	14,848,377	0.001904	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	157,168	12,073,013	0.013018	0	0	59.00
60.00	06000 LABORATORY	646,641	141,785,834	0.004561	132,131	603	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1,744	345,487	0.005048	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3,868	4,765,226	0.000812	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	72,696	18,527,313	0.003924	0	0	65.00
66.00	06600 PHYSICAL THERAPY	281,771	27,221,575	0.010351	17,991	186	66.00
67.00	06700 OCCUPATIONAL THERAPY	36,990	7,478,771	0.004946	1,716	8	67.00
68.00	06800 SPEECH PATHOLOGY	3,352	893,283	0.003752	1,703	6	68.00
69.00	06900 ELECTROCARDIOLOGY	229,525	40,919,171	0.005609	5,195	29	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	55,861	1,730,609	0.032278	637	21	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	67,379	40,169,686	0.001677	20,102	34	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	44,730	32,149,730	0.001391	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	140,068	134,982,874	0.001038	337,081	350	73.00
74.00	07400 RENAL DIALYSIS	22,994	7,324,919	0.003139	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	332,417	10,665,798	0.031167	0	0	76.00
76.01	03950 IP RENAL DIALYSIS	0	0	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	672,072	3,014,244	0.222965	0	0	90.00
91.00	09100 EMERGENCY	4,083,789	115,840,408	0.035254	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	16,450,754	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	9,926,360	1,057,613,671		516,556	1,237	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	390,697	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS		0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	390,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 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	131,600,448	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	22,780,138	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,559,423	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,297,503	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	76,826,395	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	84,813,715	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,150,875	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	54,398,102	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,848,377	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,073,013	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	141,785,834	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	345,487	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,765,226	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,527,313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,221,575	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,478,771	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	893,283	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,919,171	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,730,609	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,169,686	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,149,730	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	390,697	390,697	134,982,874	0.002894	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,324,919	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	10,665,798	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,014,244	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	115,840,408	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,450,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	390,697	390,697	1,057,613,671		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	132,131	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	17,991	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,716	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	1,703	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	5,195	0	4	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	637	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	20,102	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		0.002894	337,081	976	17,107	50	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS		0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			516,556	976	17,111	50	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 3:20 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	0.163586	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.086117	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384113	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015769	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103067	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.033101	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.157850	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.030905	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051499	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138567	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.123071	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.637141	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.012202	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.180501	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.201467	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212442	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.480728	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063163	4	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.261780	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226635	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.106883	17,107	0	0	0	1,828	73.00
74.00	07400	RENAL DIALYSIS	0.029309	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.872151	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.206576	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209002	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		17,111	0	0	0	1,828	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		17,111	0	0	0	1,828	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0180

Period:

Worksheet D

Component CCN: 14-S180

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/30/2021 3:20 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/30/2021 3:20 pm	
				Component CCN: 14-T180			
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,478,659	131,600,448	0.011236	0	0
51.00	05100	RECOVERY ROOM	119,177	22,780,138	0.005232	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	681,098	19,559,423	0.034822	0	0
53.00	05300	ANESTHESIOLOGY	24,006	28,297,503	0.000848	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	591,635	76,826,395	0.007701	24,895	192
54.01	03190	OUTPATIENT ONCOLOGY	27,167	84,813,715	0.000320	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	43,080	8,150,875	0.005285	0	0
57.00	05700	CT SCAN	80,205	54,398,102	0.001474	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,268	14,848,377	0.001904	0	0
59.00	05900	CARDIAC CATHETERIZATION	157,168	12,073,013	0.013018	0	0
60.00	06000	LABORATORY	646,641	141,785,834	0.004561	654,429	2,985
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	1,744	345,487	0.005048	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,868	4,765,226	0.000812	12,712	10
65.00	06500	RESPIRATORY THERAPY	72,696	18,527,313	0.003924	0	0
66.00	06600	PHYSICAL THERAPY	281,771	27,221,575	0.010351	1,605,207	16,615
67.00	06700	OCCUPATIONAL THERAPY	36,990	7,478,771	0.004946	905,625	4,479
68.00	06800	SPEECH PATHOLOGY	3,352	893,283	0.003752	83,090	312
69.00	06900	ELECTROCARDIOLOGY	229,525	40,919,171	0.005609	27,239	153
70.00	07000	ELECTROENCEPHALOGRAPHY	55,861	1,730,609	0.032278	2,786	90
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,379	40,169,686	0.001677	371,232	623
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,730	32,149,730	0.001391	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	140,068	134,982,874	0.001038	1,263,546	1,312
74.00	07400	RENAL DIALYSIS	22,994	7,324,919	0.003139	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	332,417	10,665,798	0.031167	0	0
76.01	03950	IP RENAL DIALYSIS	0	0	0.000000	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						
90.00	09000	CLINIC	672,072	3,014,244	0.222965	0	0
91.00	09100	EMERGENCY	4,083,789	115,840,408	0.035254	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,450,754	0.000000	0	0
200.00		Total (lines 50 through 199)	9,926,360	1,057,613,671		4,950,761	26,771

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	390,697	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS		0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	390,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	131,600,448	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	22,780,138	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,559,423	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,297,503	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	76,826,395	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	84,813,715	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,150,875	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	54,398,102	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,848,377	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,073,013	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	141,785,834	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	345,487	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,765,226	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,527,313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	27,221,575	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,478,771	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	893,283	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,919,171	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,730,609	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,169,686	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,149,730	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	390,697	390,697	134,982,874	0.002894	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,324,919	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	10,665,798	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,014,244	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	115,840,408	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,450,754	0.000000	92.00
200.00		Total (lines 50 through 199)	0	390,697	390,697	1,057,613,671		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	24,895	0	2,448	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	654,429	0	30	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	12,712	0	514	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	1,605,207	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	905,625	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	83,090	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	27,239	0	3,296	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	2,786	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	371,232	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		0.002894	1,263,546	3,657	29,159	84	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS		0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	0	0	76	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			4,950,761	3,657	35,523	84	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Subprovider - IRF		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	0.163586	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.086117	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384113	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015769	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103067	2,448	0	0	0	252	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.033101	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.157850	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.030905	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051499	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138567	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.123071	30	0	0	0	4	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.637141	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.012202	514	0	0	0	6	63.00
65.00	06500	RESPIRATORY THERAPY	0.180501	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.201467	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212442	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.480728	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063163	3,296	0	0	0	208	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.261780	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226635	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.106883	29,159	0	0	215	3,117	73.00
74.00	07400	RENAL DIALYSIS	0.029309	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.872151	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.206576	76	0	0	0	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209002	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		35,523	0	0	215	3,603	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		35,523	0	0	215	3,603	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 3:20 pm		
			Title XVIII		Subprovider - IRF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0					54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0					76.00
76.01	03950	IP RENAL DIALYSIS	0	0					76.01
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	0	23					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	23					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/30/2021 3:20 pm		
					Title XIX		Hospital		Cost		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	70,981	0.00	6,495		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	5,104	0.00	469		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	2,980	0.00	1,404		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	4,173	0.00	38		41.00		
43.00	04300	NURSERY		0	2,076	0.00	483		43.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0		44.00		
200.00		Total (lines 30 through 199)		0	85,314		8,889		200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	390,697	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	390,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description			Title XIX		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	131,600,448	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	22,780,138	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	19,559,423	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	28,297,503	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	76,826,395	0.000000
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	84,813,715	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,150,875	0.000000
57.00	05700	CT SCAN	0	0	0	54,398,102	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	14,848,377	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,073,013	0.000000
60.00	06000	LABORATORY	0	0	0	141,785,834	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	345,487	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,765,226	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,527,313	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	27,221,575	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,478,771	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	893,283	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,919,171	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,730,609	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,169,686	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,149,730	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	390,697	390,697	134,982,874	0.002894
74.00	07400	RENAL DIALYSIS	0	0	0	7,324,919	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	10,665,798	0.000000
76.01	03950	IP RENAL DIALYSIS	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,014,244	0.000000
91.00	09100	EMERGENCY	0	0	0	115,840,408	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,450,754	0.000000
200.00		Total (lines 50 through 199)	0	390,697	390,697	1,057,613,671	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 3:20 pm	
Cost Center Description				Title XIX		Hospital		Cost	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.000000	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.002894	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	0	76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 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)			70,981	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			70,981	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)			68,136	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)			15,328	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)			85,781,694	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)			85,781,694	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)			85,781,694	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)			1,208.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			18,524,195	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)			18,524,195	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0180

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:20 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
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	11,169,028	5,104	2,188.29	1,074	2,350,223
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)					13,191,599
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					34,066,017
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,525,859
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					734,013
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,259,872
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					31,806,145
	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)					2,845
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,208.52
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,438,239

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0180

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:20 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	6,658,853	85,781,694	0.077626	3,438,239	266,897
91.00	Nursing School cost	0	85,781,694	0.000000	3,438,239	0
92.00	Allied health cost	0	85,781,694	0.000000	3,438,239	0
93.00	All other Medical Education	0	85,781,694	0.000000	3,438,239	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 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)		2,980	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,980	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)		2,980	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)		450	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)		4,534,070	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)		4,534,070	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)		4,534,070	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)		1,521.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		684,675	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)		684,675	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Subprovider - IPF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						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)					63,091	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					747,766	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)					28,949	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,213	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					31,162	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					716,604	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 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	191,710	4,534,070	0.042282	0	0 90.00
91.00	Nursing School cost	0	4,534,070	0.000000	0	0 91.00
92.00	Allied health cost	0	4,534,070	0.000000	0	0 92.00
93.00	All other Medical Education	0	4,534,070	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,173	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,173	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)		4,173	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)		1,316	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,548,054	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,548,054	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,548,054	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)		850.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,118,916	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)		1,118,916	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					878,030	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,996,946	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)					90,172	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,428	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					120,600	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,876,346	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	285,927	3,548,054	0.080587	0	0 90.00
91.00	Nursing School cost	0	3,548,054	0.000000	0	0 91.00
92.00	Allied health cost	0	3,548,054	0.000000	0	0 92.00
93.00	All other Medical Education	0	3,548,054	0.000000	0	0 93.00

Health Financial Systems		PRESENCE SAINTS MARY & ELIZABETH MED		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1	
		Component CCN: 14-5541		Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XVIII	Skilled Nursing Facility	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)			0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0	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)			0	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)			0	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)			0	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)			0	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)			0	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)				38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)				39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)				40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)				41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					0	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0.00	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0180

Period:

Worksheet D-1

Component CCN: 14-5541

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 3:20 pm

Title XVIII

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 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)		70,981	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,981	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)		68,136	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)		6,495	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)		2,076	15.00	
16.00	Nursery days (title V or XIX only)		483	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)		85,781,694	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)		85,781,694	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)		85,781,694	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)		1,208.52	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,849,337	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)		7,849,337	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0180

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:20 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,738,362	2,076	837.36	483	404,445	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,169,028	5,104	2,188.29	469	1,026,308	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						9,280,090 49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						2,845 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,208.52 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						3,438,239 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0180

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		Title XIX		Hospital		Cost
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,658,853	85,781,694	0.077626	3,438,239	266,897
91.00	Nursing School cost	0	85,781,694	0.000000	3,438,239	0
92.00	Allied health cost	0	85,781,694	0.000000	3,438,239	0
93.00	All other Medical Education	0	85,781,694	0.000000	3,438,239	0

Health Financial Systems		PRESENCE SAINTS MARY & ELIZABETH MED		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1	
		Component CCN: 14-T180		Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,173	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,173	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)			4,173	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)			38	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)			2,076	15.00
16.00	Nursery days (title V or XIX only)			483	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,535,391	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,535,391	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,535,391	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)			847.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			32,194	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)			32,194	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm	
				Title XIX		Subprovider - IRF	Cost
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					32,194	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XIX		Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	285,927	3,535,391	0.080876	0	0	90.00
91.00 Nursing School cost	0	3,535,391	0.000000	0	0	91.00
92.00 Allied health cost	0	3,535,391	0.000000	0	0	92.00
93.00 All other Medical Education	0	3,535,391	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 3:20 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			30.00
31.00	03100	INTENSIVE CARE UNIT	54,510,983		31.00
40.00	04000	SUBPROVIDER - IPF	9,448,233		40.00
41.00	04100	SUBPROVIDER - IRF	1,023,691		41.00
43.00	04300	NURSERY	23,709		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.164840	9,393,987	50.00
51.00	05100	RECOVERY ROOM	0.086117	1,826,792	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.384113	56,280	52.00
53.00	05300	ANESTHESIOLOGY	0.015769	1,948,651	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.103067	4,144,252	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.033101	5,275	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.157850	8,185	55.00
57.00	05700	CT SCAN	0.030905	5,260,697	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.051499	824,922	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138567	2,102,572	59.00
60.00	06000	LABORATORY	0.123071	19,338,822	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.637141	202	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.012202	942,285	63.00
65.00	06500	RESPIRATORY THERAPY	0.180501	5,328,171	65.00
66.00	06600	PHYSICAL THERAPY	0.201467	1,312,420	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.212442	559,365	67.00
68.00	06800	SPEECH PATHOLOGY	0.480728	201,296	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063163	4,958,224	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.262112	37,719	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504	5,320,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226635	3,777,621	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.106883	20,673,328	73.00
74.00	07400	RENAL DIALYSIS	0.029309	2,670,957	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116	992	76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.872151	0	90.00
91.00	09100	EMERGENCY	0.206685	7,846,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209002	622,881	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		99,163,314	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)		99,163,314	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		1,125,542		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.164840	0	0	50.00
51.00	05100 RECOVERY ROOM	0.086117	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.384113	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.015769	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.103067	0	0	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.033101	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.157850	0	0	55.00
57.00	05700 CT SCAN	0.030905	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.051499	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.138567	0	0	59.00
60.00	06000 LABORATORY	0.123071	132,131	16,261	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.637141	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.012202	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.180501	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.201467	17,991	3,625	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.212442	1,716	365	67.00
68.00	06800 SPEECH PATHOLOGY	0.480728	1,703	819	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063163	5,195	328	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.262112	637	167	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504	20,102	5,498	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.226635	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.106883	337,081	36,028	73.00
74.00	07400 RENAL DIALYSIS	0.029309	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116	0	0	76.00
76.01	03950 IP RENAL DIALYSIS	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.872151	0	0	90.00
91.00	09100 EMERGENCY	0.206685	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209002	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		516,556	63,091	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)		516,556		202.00

Health Financial Systems		PRESENCE SAINTS MARY & ELIZABETH MED		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180	Period: From 07/01/2020	Worksheet D-3	
		Component CCN: 14-T180	To 06/30/2021	Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		3,903,525		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.164840	0	0	50.00
51.00	05100 RECOVERY ROOM	0.086117	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.384113	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.015769	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.103067	24,895	2,566	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.033101	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.157850	0	0	55.00
57.00	05700 CT SCAN	0.030905	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.051499	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.138567	0	0	59.00
60.00	06000 LABORATORY	0.123071	654,429	80,541	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.637141	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.012202	12,712	155	63.00
65.00	06500 RESPIRATORY THERAPY	0.180501	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.201467	1,605,207	323,396	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.212442	905,625	192,393	67.00
68.00	06800 SPEECH PATHOLOGY	0.480728	83,090	39,944	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063163	27,239	1,720	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.262112	2,786	730	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.273504	371,232	101,533	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.226635	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.106883	1,263,546	135,052	73.00
74.00	07400 RENAL DIALYSIS	0.029309	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.682116	0	0	76.00
76.01	03950 IP RENAL DIALYSIS	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.872151	0	0	90.00
91.00	09100 EMERGENCY	0.206685	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209002	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,950,761	878,030	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)		4,950,761		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 3:20 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)		5,421,658	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		16,900,216	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)		182,971	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		651,223	2.04
3.00	Managed Care Simulated Payments		15,119,664	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		323.27	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)		52.59	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)		1.50	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		10.00	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)		61.09	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		54.80	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.00	11.00
12.00	Current year allowable FTE (see instructions)		57.80	12.00
13.00	Total allowable FTE count for the prior year.		56.47	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.		54.46	14.00
15.00	Sum of lines 12 through 14 divided by 3.		56.24	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		56.24	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.173972	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.158601	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.158601	21.00
22.00	IME payment adjustment (see instructions)		1,851,309	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,253,980	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)		-6.29	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)		1,851,309	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,253,980	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		19.24	30.00
31.00	Percentage of Medicaid patient days (see instructions)		47.29	31.00
32.00	Sum of lines 30 and 31		66.53	32.00
33.00	Allowable disproportionate share percentage (see instructions)		44.10	33.00
34.00	Disproportionate share adjustment (see instructions)		2,460,987	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 3:20 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
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,733,820	2,078,501	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	687,189	1,554,604	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,241,793		
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	
			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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		
47.00	Subtotal (see instructions)	29,710,157		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		30,964,137	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,912,906	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		1,940,852	
53.00	Nursing and Allied Health Managed Care payment		19,507	
54.00	Special add-on payments for new technologies		344,171	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		59,829	
59.00	Total (sum of amounts on lines 49 through 58)		35,241,402	
60.00	Primary payer payments		0	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,241,402	
62.00	Deductibles billed to program beneficiaries		2,004,884	
63.00	Coinsurance billed to program beneficiaries		362,822	
64.00	Allowable bad debts (see instructions)		1,575,887	
65.00	Adjusted reimbursable bad debts (see instructions)		1,024,327	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		964,142	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		33,898,023	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		-25,396	
70.94	HRR adjustment amount (see instructions)		-63,614	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 3:20 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)		33,809,013	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		33,309,529	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		499,484	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,186,347	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 3:20 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,421,658	0	5,421,658		5,421,658	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	16,900,216	0		16,900,216	16,900,216	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	182,971	0	182,971		182,971	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	651,223	0		651,223	651,223	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,119,664	0	3,529,613	11,590,051	15,119,664	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.158601	0.158601	0.158601	0.158601		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,851,309	0	449,656	1,401,653	1,851,309	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,253,980	0	292,736	961,244	1,253,980	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,851,309	0	449,656	1,401,653	1,851,309	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,253,980	0	292,736	961,244	1,253,980	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4410	0.4410	0.4410	0.4410		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,460,987	0	597,738	1,863,249	2,460,987	11.00
11.01	Uncompensated care payments	36.00	2,241,793	0	9,138,092	2,298,846	11,436,938	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	29,710,157	0	15,790,115	13,920,042	29,710,157	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	30,964,137	0	16,082,851	14,881,286	30,964,137	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,912,906	0	477,143	1,435,763	1,912,906	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 3:20 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	344,171	0	0	344,171	344,171	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	16,559,994	16,661,220	33,221,214	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,717,239	0	429,327	1,287,912	1,717,239	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	55,197	0	12,697	42,500	55,197	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0818	0.0818	0.0818	0.0818		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	140,470	0	35,119	105,351	140,470	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,912,906	0	477,143	1,435,763	1,912,906	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 3:20 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	5,421,658	5,421,658		5,421,658	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	16,900,216		16,900,216	16,900,216	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	182,971	182,971		182,971	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	651,223		651,223	651,223	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,119,664	3,529,613	11,590,051	15,119,664	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.158601	0.158601	0.158601		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,851,309	449,656	1,401,653	1,851,309	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,253,980	292,736	961,244	1,253,980	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,851,309	449,656	1,401,653	1,851,309	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,253,980	292,736	961,244	1,253,980	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4410	0.4410	0.4410		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,460,987	597,738	1,863,249	2,460,987	11.00
11.01	Uncompensated care payments	36.00	2,241,793	2,153,141	4,862,037	7,015,178	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	29,710,157	8,805,164	20,904,993	29,710,157	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	30,964,137	9,097,900	21,866,237	30,964,137	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,912,906	477,143	1,435,763	1,912,906	16.00
17.00	Special add-on payments for new technologies	54.00	344,171	0	344,171	344,171	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,575,043	23,646,171	33,221,214	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 3:20 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	1,717,239	429,327	1,287,912	1,717,239	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	55,197	12,697	42,500	55,197	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	0.0818	0.0818	0.0818		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	140,470	35,119	105,351	140,470	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,912,906	477,143	1,435,763	1,912,906	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	-25,396	26,325	-51,721	-25,396	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	-63,614	-22,228	-41,386	-63,614	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: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 3:20 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,701	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,456,688	2.00
3.00	OPPS payments		12,786,284	3.00
4.00	Outlier payment (see instructions)		43,080	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		105,895	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		12,701	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		118,106	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)		118,106	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)		118,106	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		105,405	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)		12,701	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)		12,935,259	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)		2,478,807	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)		10,469,153	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		715,949	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)		11,185,102	30.00
31.00	Primary payer payments		1,836	31.00
32.00	Subtotal (line 30 minus line 31)		11,183,266	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)		782,706	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		508,759	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		404,594	36.00
37.00	Subtotal (see instructions)		11,692,025	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-29	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)		11,692,054	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		11,692,811	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)		-757	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		2,178	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: 14-0180 Component CCN: 14-S180	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 3:20 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)		1,778	2.00
3.00	OPPS payments		589	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		50	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)		639	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)		163	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)		476	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)		476	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		476	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)		476	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)		476	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		426	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)		50	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: 14-0180 Component CCN: 14-T180	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 3:20 pm
		Title XVIII	Subprovider - IRF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		23	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,519	2.00
3.00	OPPS payments		2,081	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		84	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		23	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		215	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)		215	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)		215	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		192	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)		23	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)		2,165	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)		408	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,780	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,780	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,780	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,780	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,780	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		1,702	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)		78	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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 3:20 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		29,985,189		10,353,742	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		2,990,799		1,234,520	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	02/10/2021	333,541	02/10/2021	104,549	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)		333,541		104,549	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)		33,309,529		11,692,811	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		499,484		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		757	6.02
7.00	Total Medicare program liability (see instructions)		33,809,013		11,692,054	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: 14-0180

Period:

Worksheet E-1

Component CCN: 14-S180

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 3:20 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		507,692		426	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)		507,692		426	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		12,553		50	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		520,245		476	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: 14-0180

Period:

Worksheet E-1

Component CCN: 14-T180

From 07/01/2020

Part I

To 06/30/2021

Date/Time Prepared:

11/30/2021 3:20 pm

Title XVIII

Subprovider -

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		2,746,951		1,702	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	02/10/2021	6,725		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)		6,725		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)		2,753,676		1,702	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		1,495		78	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,755,171		1,780	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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 3:20 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: 14-0180 Component CCN: 14-S180	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/30/2021 3:20 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)			451,322 1.00
2.00	Net IPF PPS Outlier Payments			99,245 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)			8.164384 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)			550,567 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)			550,567 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			550,567 18.00
19.00	Deductibles			41,020 19.00
20.00	Subtotal (line 18 minus line 19)			509,547 20.00
21.00	Coinurance			1,855 21.00
22.00	Subtotal (line 20 minus line 21)			507,692 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			17,811 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			11,577 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,311 25.00
26.00	Subtotal (sum of lines 22 and 24)			519,269 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			976 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)			520,245 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			507,692 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)			12,553 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			99,245 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

Health Financial Systems		PRESENCE SAINTS MARY & ELIZABETH MED		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/30/2021 3:20 pm	
		Component CCN: 14-T180			
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
PART III - MEDICARE PART A SERVICES - IRF PPS					
1.00	Net Federal PPS Payment (see instructions)			2,485,970	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.1426	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			281,163	3.00
4.00	Outlier Payments			0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5.01
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00	9.00
10.00	Average Daily Census (see instructions)			11.432877	10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000	11.00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			2,767,133	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0	16.00
17.00	Subtotal (see instructions)			2,767,133	17.00
18.00	Primary payer payments			0	18.00
19.00	Subtotal (line 17 less line 18).			2,767,133	19.00
20.00	Deductibles			12,976	20.00
21.00	Subtotal (line 19 minus line 20)			2,754,157	21.00
22.00	Coinsurance			15,430	22.00
23.00	Subtotal (line 21 minus line 22)			2,738,727	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			19,672	24.00
25.00	Adjusted reimbursable bad debts (see instructions)			12,787	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,752	26.00
27.00	Subtotal (sum of lines 23 and 25)			2,751,514	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0	28.00
29.00	Other pass through costs (see instructions)			3,657	29.00
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	31.50
31.99	Demonstration payment adjustment amount before sequestration			0	31.99
32.00	Total amount payable to the provider (see instructions)			2,755,171	32.00
32.01	Sequestration adjustment (see instructions)			0	32.01
32.02	Demonstration payment adjustment amount after sequestration			0	32.02
33.00	Interim payments			2,753,676	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			1,495	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	36.00
TO BE COMPLETED BY CONTRACTOR					
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			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: 14-0180 Component CCN: 14-5541	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 11/30/2021 3:20 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 3:20 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	9,280,090			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)	9,280,090		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)	9,280,090		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)	9,280,090		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	9,280,090		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		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

Health Financial Systems		PRESENCE SAINTS MARY & ELIZABETH MED		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 07/01/2020	Worksheet E-3	
		Component CCN: 14-T180	To 06/30/2021	Part VII Date/Time Prepared: 11/30/2021 3:20 pm	
		Title XIX	Subprovider - IRF	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	32,194			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)	32,194		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)	32,194		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)	32,194		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	32,194		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		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: 14-0180		Period: From 07/01/2020 To 06/30/2021		Worksheet E-4 Date/Time Prepared: 11/30/2021 3:20 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.					41.12	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)					2.82	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))					17.00	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)					55.30	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					54.80	6.00
7.00	Enter the lesser of line 5 or line 6					54.80	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.	49.67		5.13		54.80	
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.	49.67		5.13		54.80	
10.00	Weighted dental and podiatric resident FTE count for the current year			3.00		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	49.67		8.13		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	46.61		8.08		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	46.39		8.04		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	47.56		8.08		14.00	
15.00	Adjustment for residents in initial years of new programs	0.00		0.00		15.00	
15.01	Unweighted adjustment for residents in initial years of new programs	0.00		0.00		15.01	
16.00	Adjustment for residents displaced by program or hospital closure	0.00		0.00		16.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00		0.00		16.01	
17.00	Adjusted rolling average FTE count	47.56		8.08		17.00	
18.00	Per resident amount	135,496.99		135,496.99		18.00	
19.00	Approved amount for resident costs	6,444,237		1,094,816		7,539,053	
						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	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00	
24.00	Multiply line 22 time line 23					0	
25.00	Total direct GME amount (sum of lines 19 and 24)					7,539,053	
		Inpatient Part A		Managed Care Prior to 1/1		Managed Care On or after 1/1	
		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)	18,168		5,126		5,640	
27.00	Total Inpatient Days (see instructions)	80,861		80,861		80,861	
28.00	Ratio of inpatient days to total inpatient days	0.224682		0.063393		0.069749	
29.00	Program direct GME amount	1,693,890		477,923		525,841	
29.01	Percent reduction for MA DGME			4.07		4.07	
30.00	Reduction for direct GME payments for Medicare Advantage			19,451		21,402	
31.00	Net Program direct GME amount					2,656,801	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/30/2021 3:20 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)		7,324,919	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)		36,810,729	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)		36,810,729	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		13,580,738	42.00
43.00	Primary payer payments (see instructions)		1,836	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		13,578,902	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		50,389,631	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.730522	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.269478	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		2,656,801	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		1,940,852	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		715,949	50.00

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

Provider CCN: 14-0180

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

Worksheet G

Date/Time Prepared:
11/30/2021 3:20 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	7,091	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	133,426,495	0	0	0	4.00
5.00 Other receivable	4,665,471	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-96,216,847	0	0	0	6.00
7.00 Inventory	5,578,397	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	2,671,993	0	0	0	9.00
10.00 Due from other funds	16,975,110	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	67,107,710	0	0	0	11.00
FIXED ASSETS					
12.00 Land	35,010,000	0	0	0	12.00
13.00 Land improvements	451,226	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	139,324,668	0	0	0	15.00
16.00 Accumulated depreciation	-32,065,514	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	29,889,281	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	0	0	0	0	23.00
24.00 Accumulated depreciation	0	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)	172,609,661	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	1,109,085	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,109,085	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	240,826,456	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	3,996,401	0	0	0	37.00
38.00 Salaries, wages, and fees payable	3,033,137	0	0	0	38.00
39.00 Payroll taxes payable	389,831	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	21,465,662	0	0	0	43.00
44.00 Other current liabilities	87,519,945	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	116,404,976	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	3,105,459	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	3,105,459	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	119,510,435	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	121,316,019				52.00
53.00 Specific purpose fund		0			53.00
54.00 Donor created - endowment fund balance - restricted			0		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	121,316,019	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	240,826,454	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0180

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

Worksheet G-1

Date/Time Prepared:
11/30/2021 3:20 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		139,984,706		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,335,684				2.00
3.00	Total (sum of line 1 and line 2)		148,320,390		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER TRANSFERS	488,084		0		0	5.00
6.00	NET ASSET TRANSFERS	1,196,002		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)		1,684,086		0		10.00
11.00	Subtotal (line 3 plus line 10)		150,004,476		0		11.00
12.00	NET ASSET TRANSFERS	28,688,457		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)		28,688,457		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		121,316,019		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	OTHER TRANSFERS		0				5.00
6.00	NET ASSET TRANSFERS		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	NET ASSET TRANSFERS		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: 14-0180

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 3:20 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	233,368,758		233,368,758	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	19,961,106		19,961,106	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)	253,329,864		253,329,864	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	31,910,783		31,910,783	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)	31,910,783		31,910,783	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	285,240,647		285,240,647	17.00
18.00	Ancillary services	369,105,090	553,203,174	922,308,264	18.00
19.00	Outpatient services	34,606,879	100,698,527	135,305,406	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	PHYSICIAN AND OP PHARM REV	0	5,970,149	5,970,149	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	688,952,616	659,871,850	1,348,824,466	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		310,211,088		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	ADD (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)		310,211,088		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0180

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

Worksheet G-3

Date/Time Prepared:
11/30/2021 3:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,348,824,466	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,056,692,542	2.00
3.00	Net patient revenues (line 1 minus line 2)	292,131,924	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	310,211,088	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-18,079,164	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	27,361,596	24.00
24.01	MISCELLANEOUS REVENUE	0	24.01
24.50	COVID-19 PHE Funding	500,000	24.50
25.00	Total other income (sum of lines 6-24)	27,861,596	25.00
26.00	Total (line 5 plus line 25)	9,782,432	26.00
27.00	RECONCILING ITEM	1,446,748	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,446,748	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,335,684	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0180	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/30/2021 3:20 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,717,239	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		55,197	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)		201.94	3.00
4.00	Number of interns & residents (see instructions)		56.24	4.00
5.00	Indirect medical education percentage (see instructions)		8.18	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)		140,470	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,912,906	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