

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: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 7/28/2022 11:51 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SOUTH SHORE HOSPITAL CORPORATION (14-0181) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Leslie Rogers	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Leslie Rogers		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-850,296	33,573	0	0	1.00
2.00 Subprovider - IPF	0	52,610	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200.00 Total	0	-797,686	33,573	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: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2022 11:51 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 8012 SOUTH CRANDON AVENUE			PO Box:				1.00			
2.00	City: CHICAGO			State: IL		Zip Code: 60617-1175		County: COOK			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SOUTH SHORE HOSPITAL CORPORATION		140181	16984	1	07/01/1966	N	P	P
4.00	Subprovider - IPF		SOUTH SHORE HOSPITAL PSYCH UNIT		14S181	16974	4	01/01/2013	N	P	N
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021		12/31/2021		20.00
21.00	Type of Control (see instructions)						2				21.00
						1.00	2.00	3.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0181

Period:
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Date/Time Prepared:
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	263	0	0	0	3,602	448	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	Y
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
			1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00		
			Y/N	IME	Direct GME	IME	Direct GME		
			1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
							1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
			1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 7/28/2022 11:51 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	300,000	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2022 11:51 am	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
						Beginning	Ending
						1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170.00
						1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/28/2022 11:51 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N	A	12/31/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/16/2022	Y	05/16/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 7/28/2022 11:51 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		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	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	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.		N	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.	TONY	LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/28/2022 11:51 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT	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: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2022 11:51 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	114	41,610	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)		114	41,610	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		122	44,530	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	15	5,475		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		137			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2022 11:51 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,617	336	11,134			1.00
2.00	HMO and other (see instructions)	0	3,847				2.00
3.00	HMO IPF Subprovider	0	1,534				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,617	336	11,134			7.00
8.00	INTENSIVE CARE UNIT	441	130	866			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						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	5,058	466	12,000	0.00	259.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,156	40	3,636	0.00	16.79	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	276.44	27.00
28.00	Observation Bed Days		31	1,865			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2022 11:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	507	53	1,367	1.00
2.00 HMO and other (see instructions)			0	432		2.00
3.00 HMO IPF Subprovider				190		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	507	53	1,367	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	126	4	417	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/28/2022 11:51 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	20,478,371	0	20,478,371	574,992.00	35.62
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,531,408	74,228	1,605,636	43,103.00	37.25
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,433,093	0	2,433,093	31,061.00	78.33
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		780,493	0	780,493	5,203.00	150.01
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,482,433	0	3,482,433		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		281,471	0	281,471		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/28/2022 11:51 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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	267,633	0	267,633	8,240.00	32.48	26.00
27.00	Administrative & General	5.00	3,870,959	-74,228	3,796,731	112,792.00	33.66	27.00
28.00	Administrative & General under contract (see inst.)		312,556	0	312,556	5,078.00	61.55	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	867,371	0	867,371	21,726.00	39.92	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	643,914	0	643,914	31,453.00	20.47	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	655,007	0	655,007	35,777.00	18.31	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	888,310	0	888,310	20,539.00	43.25	38.00
39.00	Central Services and Supply	14.00	98,066	0	98,066	5,695.00	17.22	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	423,549	0	423,549	18,124.00	23.37	41.00
42.00	Social Service	17.00	95,787	0	95,787	3,965.00	24.16	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
7/28/2022 11:51 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	20,790,927	0	20,790,927	580,070.00	35.84	1.00
2.00	Excluded area salaries (see instructions)	1,531,408	74,228	1,605,636	43,103.00	37.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,259,519	-74,228	19,185,291	536,967.00	35.73	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,213,586	0	3,213,586	36,264.00	88.62	4.00
5.00	Subtotal wage-related costs (see inst.)	3,482,433	0	3,482,433	0.00	18.15	5.00
6.00	Total (sum of lines 3 thru 5)	25,955,538	-74,228	25,881,310	573,231.00	45.15	6.00
7.00	Total overhead cost (see instructions)	8,123,152	-74,228	8,048,924	263,389.00	30.56	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 7/28/2022 11:51 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		228,382	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)		1,527,186	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		26,523	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		30,103	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)		87,904	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		260,256	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,537,001	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		51,000	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		15,549	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,763,904	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,433,093	3,763,904	1.00
2.00	Hospital	2,433,093	3,482,433	2.00
3.00	SUBPROVIDER - IPF	0	281,471	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			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 I	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		SOUTH SHORE HOSPITAL CORPORATION		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10	
				Date/Time Prepared: 7/28/2022 11:51 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.295958	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			22,623,350	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			61,088,665	6.00
7.00	Medicaid cost (line 1 times line 6)			18,079,679	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)	4,452,652	19,445	4,472,097	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,317,798	19,445	1,337,243	21.00
22.00	Payments received from patients for amounts previously written off as charity care	300,279	0	300,279	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,017,519	19,445	1,036,964	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)			1,183,712	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			299,469	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			460,721	27.01
28.00	Non-Medicare bad debt expense (see instructions)			722,991	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			375,227	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,412,191	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,412,191	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0181

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

Worksheet A

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,038,163	1,038,163	-354,383	683,780	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	354,383	354,383	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	267,633	3,127,702	3,395,335	-766,795	2,628,540	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,870,959	6,857,653	10,728,612	676,826	11,405,438	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	867,371	868,262	1,735,633	0	1,735,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	19,120	19,120	8.00
9.00	00900	HOUSEKEEPING	643,914	177,791	821,705	-19,120	802,585	9.00
10.00	01000	DIETARY	655,007	317,770	972,777	0	972,777	10.00
11.00	01100	CAFETERIA	0	206,606	206,606	0	206,606	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	888,310	129,290	1,017,600	-1,329	1,016,271	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	98,066	351,266	449,332	-320,556	128,776	14.00
15.00	01500	PHARMACY	0	2,560,521	2,560,521	-529,702	2,030,819	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	423,549	238,834	662,383	0	662,383	16.00
17.00	01700	SOCIAL SERVICE	95,787	23,201	118,988	0	118,988	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,196,185	1,796,508	5,992,693	-168,261	5,824,432	30.00
31.00	03100	INTENSIVE CARE UNIT	1,498,238	199,166	1,697,404	-13,093	1,684,311	31.00
40.00	04000	SUBPROVIDER - IPF	1,395,164	535,604	1,930,768	0	1,930,768	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	434,290	342,467	776,757	-129,724	647,033	50.00
51.00	05100	RECOVERY ROOM	155,830	16,062	171,892	-256	171,636	51.00
53.00	05300	ANESTHESIOLOGY	15,749	515,561	531,310	-5,456	525,854	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,560	525,499	955,059	-1,362	953,697	54.00
54.01	03630	ULTRA SOUND	139,775	31,533	171,308	-987	170,321	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	114,132	114,132	-11,366	102,766	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,006,029	963,296	1,969,325	0	1,969,325	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	73,526	206,709	280,235	-30,262	249,973	63.00
65.00	06500	RESPIRATORY THERAPY	695,833	462,926	1,158,759	-93,674	1,065,085	65.00
66.00	06600	PHYSICAL THERAPY	147,328	49,758	197,086	-220	196,866	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	97,959	224,378	322,337	-3,871	318,466	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	934,615	934,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,958	13,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	458,716	458,716	73.00
74.00	07400	RENAL DIALYSIS	0	362,211	362,211	0	362,211	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	50,377	50,377	-24,254	26,123	90.01
91.00	09100	EMERGENCY	2,246,065	2,128,239	4,374,304	-72,916	4,301,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,342,127	24,421,485	44,763,612	-89,969	44,673,643	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	136,244	120,922	257,166	0	257,166	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	24,295	24,295	194.01
194.02	07952	MARKETING OTHER	0	0	0	65,674	65,674	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	20,478,371	24,542,407	45,020,778	0	45,020,778	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0181

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

Worksheet A

Date/Time Prepared:
7/28/2022 11:51 am

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	0	683,780	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	354,383	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,628,540	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-249,204	11,156,234	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-49,250	1,686,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,120	8.00
9.00	00900	HOUSEKEEPING	0	802,585	9.00
10.00	01000	DIETARY	0	972,777	10.00
11.00	01100	CAFETERIA	-86,250	120,356	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,016,271	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,175	125,601	14.00
15.00	01500	PHARMACY	0	2,030,819	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-188	662,195	16.00
17.00	01700	SOCIAL SERVICE	0	118,988	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-444,437	5,379,995	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,684,311	31.00
40.00	04000	SUBPROVIDER - IPF	-180,875	1,749,893	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-26,641	620,392	50.00
51.00	05100	RECOVERY ROOM	0	171,636	51.00
53.00	05300	ANESTHESIOLOGY	-504,167	21,687	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,898	949,799	54.00
54.01	03630	ULTRA SOUND	0	170,321	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	102,766	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-32,075	1,937,250	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	249,973	63.00
65.00	06500	RESPIRATORY THERAPY	-11,308	1,053,777	65.00
66.00	06600	PHYSICAL THERAPY	0	196,866	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-199,310	119,156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	934,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	458,716	73.00
74.00	07400	RENAL DIALYSIS	0	362,211	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CARE	-24,150	1,973	90.01
91.00	09100	EMERGENCY	-1,283,292	3,018,096	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
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,098,220	41,575,423	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	257,166	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	FUND RAISING	0	24,295	194.01
194.02	07952	MARKETING OTHER	0	65,674	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,098,220	41,922,558	200.00

RECLASSIFICATIONS

Provider CCN: 14-0181

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

Worksheet A-6

Date/Time Prepared:
7/28/2022 11:51 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES SOLD TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	934,615		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,958		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
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
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
	TOTALS		0	948,573		
	B - FUNDRAISING					
1.00	FUND RAISING	194.01	22,494	1,801		1.00
	TOTALS		22,494	1,801		
	C - MARKETING					
1.00	MARKETING OTHER	194.02	51,734	13,940		1.00
	TOTALS		51,734	13,940		
	D - NON BENEFITS TO A & G					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	766,795		1.00
	TOTALS		0	766,795		
	E - DRUGS CHARGED T					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	458,716		1.00
	TOTALS		0	458,716		
	G - LAUNDRY COSTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	19,120		1.00
	TOTALS		0	19,120		
	H - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	354,383		1.00
	TOTALS		0	354,383		
500.00	Grand Total: Increases		74,228	2,563,328		500.00

RECLASSIFICATIONS

Provider CCN: 14-0181

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

Worksheet A-6

Date/Time Prepared:
7/28/2022 11:51 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL SUPPLIES SOLD TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	320,556	0		1.00
2.00	PHARMACY	15.00	0	70,986	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	168,261	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	13,093	0		4.00
6.00	OPERATING ROOM	50.00	0	129,724	0		6.00
7.00	RECOVERY ROOM	51.00	0	256	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	5,456	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,362	0		9.00
10.00	ULTRA SOUND	54.01	0	987	0		10.00
11.00	CT SCAN	57.00	0	11,366	0		11.00
13.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	30,262	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	93,674	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	220	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	3,871	0		16.00
17.00	WOUND CARE	90.01	0	24,254	0		17.00
18.00	EMERGENCY	91.00	0	72,916	0		18.00
19.00	NURSING ADMINISTRATION	13.00	0	1,329	0		19.00
	TOTALS		0	948,573			
	B - FUNDRAISING						
1.00	ADMINISTRATIVE & GENERAL	5.00	22,494	1,801	0		1.00
	TOTALS		22,494	1,801			
	C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	51,734	13,940	0		1.00
	TOTALS		51,734	13,940			
	D - NON BENEFITS TO A & G						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	766,795	0		1.00
	TOTALS		0	766,795			
	E - DRUGS CHARGED T						
1.00	PHARMACY	15.00	0	458,716	0		1.00
	TOTALS		0	458,716			
	G - LAUNDRY COSTS						
1.00	HOUSEKEEPING	9.00	0	19,120	0		1.00
	TOTALS		0	19,120			
	H - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	354,383	9		1.00
	TOTALS		0	354,383			
500.00	Grand Total: Decreases		74,228	2,563,328			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
7/28/2022 11:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,428,579	0	0	0	0	1.00
2.00	Land Improvements	1,100,274	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,797,747	226,685	0	226,685	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	10,958,278	145,224	0	145,224	-4,554	5.00
6.00	Movable Equipment	22,166,873	238,909	0	238,909	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,451,751	610,818	0	610,818	-4,554	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,451,751	610,818	0	610,818	-4,554	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,428,579	0				1.00
2.00	Land Improvements	1,100,274	0				2.00
3.00	Buildings and Fixtures	18,024,432	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	11,108,056	0				5.00
6.00	Movable Equipment	22,405,782	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	54,067,123	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	54,067,123	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	946,713	0	91,450	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)	946,713	0	91,450	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,038,163				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,038,163				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	30,225,208	0	30,225,208	0.574335	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	22,401,228	0	22,401,228	0.425665	0	2.00
3.00	Total (sum of lines 1-2)	52,626,436	0	52,626,436	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	592,330	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	354,383	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	946,713	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	91,450	0	0	0	683,780	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	354,383	2.00
3.00	Total (sum of lines 1-2)	91,450	0	0	0	1,038,163	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0181

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

Worksheet A-8

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				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)	B	-3,175	CENTRAL SERVICES & SUPPLY	14.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-40,843	ADMINISTRATIVE & GENERAL	5.00	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	-2,787,846			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-86,250	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-49,250	OPERATION OF PLANT	7.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-188	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-190	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OFFSET A & G MISC INCOME	B	-41,405	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0181

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

Worksheet A-8

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
34.00	LOBBY EXPENSE	A	-13,737	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	LOBBYIEST EXPENSE	A	-75,336	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,098,220				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0181

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2022 11:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	444,437	444,437	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	180,875	180,875	0	0	0	3.00
4.00	50.00	OPERATING ROOM	126,741	0	126,741	246,400	845	4.00
5.00	53.00	ANESTHESIOLOGY	504,167	504,167	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	30,304	0	30,304	271,900	202	6.00
7.00	60.00	LABORATORY	193,511	0	193,511	260,300	1,290	7.00
8.00	65.00	RESPIRATORY THERAPY	35,000	0	35,000	211,500	233	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	199,310	199,310	0	0	0	10.00
11.00	90.01	WOUND CARE	24,150	24,150	0	0	0	11.00
12.00	91.00	EMERGENCY	1,458,695	1,200,000	258,695	211,500	1,725	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	77,693	77,693	0	0	0	13.00
200.00			3,274,883	2,630,632	644,251		4,295	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	100,100	5,005	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	26,406	1,320	0	0	0	6.00
7.00	60.00	LABORATORY	161,436	8,072	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	23,692	1,185	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.01	WOUND CARE	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	175,403	8,770	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	13.00
200.00			487,037	24,352	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	444,437		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	180,875		3.00
4.00	50.00	OPERATING ROOM	0	100,100	26,641	26,641		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	504,167		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	26,406	3,898	3,898		6.00
7.00	60.00	LABORATORY	0	161,436	32,075	32,075		7.00
8.00	65.00	RESPIRATORY THERAPY	0	23,692	11,308	11,308		8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	199,310		10.00
11.00	90.01	WOUND CARE	0	0	0	24,150		11.00
12.00	91.00	EMERGENCY	0	175,403	83,292	1,283,292		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	77,693		13.00
200.00			0	487,037	157,214	2,787,846		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	683,780	683,780			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	354,383		354,383		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,628,540	1,690	581	2,630,811	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,156,234	68,826	175,008	494,217	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,686,383	49,099	1,833	112,905	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,120	4,918	0	0	8.00
9.00	00900	HOUSEKEEPING	802,585	15,765	0	83,818	9.00
10.00	01000	DIETARY	972,777	15,035	591	85,262	10.00
11.00	01100	CAFETERIA	120,356	13,939	436	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,016,271	5,803	8,330	115,630	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	125,601	8,720	1,215	12,765	14.00
15.00	01500	PHARMACY	2,030,819	8,322	144	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662,195	3,218	1,052	55,133	16.00
17.00	01700	SOCIAL SERVICE	118,988	689	0	12,468	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,379,995	237,410	24,418	546,213	30.00
31.00	03100	INTENSIVE CARE UNIT	1,684,311	21,195	11,258	195,024	31.00
40.00	04000	SUBPROVIDER - IPF	1,749,893	48,154	12,427	181,607	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	620,392	44,166	39,259	56,531	50.00
51.00	05100	RECOVERY ROOM	171,636	3,118	1,406	20,284	51.00
53.00	05300	ANESTHESIOLOGY	21,687	2,082	13,582	2,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	949,799	29,301	20,840	55,915	54.00
54.01	03630	ULTRA SOUND	170,321	1,609	9,862	18,194	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	102,766	2,962	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,937,250	21,120	3,297	130,954	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	249,973	1,559	895	9,571	63.00
65.00	06500	RESPIRATORY THERAPY	1,053,777	12,521	10,497	90,576	65.00
66.00	06600	PHYSICAL THERAPY	196,866	16,071	1,057	19,178	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,946	0	68.00
69.00	06900	ELECTROCARDIOLOGY	119,156	7,256	10,271	12,751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	934,615	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,958	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	458,716	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	362,211	1,433	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	1,973	1,448	0	0	90.01
91.00	09100	EMERGENCY	3,018,096	35,748	1,689	292,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,575,423	683,177	351,894	2,603,414	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	603	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	257,166	0	2,489	17,735	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	FUND RAISING	24,295	0	0	2,928	194.01
194.02	07952	MARKETING OTHER	65,674	0	0	6,734	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	41,922,558	683,780	354,383	2,630,811	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,894,285					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	732,878	0	2,583,098			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,522	0	22,517	56,077		8.00
9.00	00900	HOUSEKEEPING	357,351	0	72,180	5,390	1,337,089	9.00
10.00	01000	DIETARY	425,282	0	68,841	0	0	10.00
11.00	01100	CAFETERIA	53,367	0	63,822	0	18,701	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	453,948	0	26,570	0	9,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,742	0	39,923	0	37,401	14.00
15.00	01500	PHARMACY	807,767	0	38,105	0	18,701	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,827	0	14,735	0	42,076	16.00
17.00	01700	SOCIAL SERVICE	52,343	0	3,154	0	4,675	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,451,097	0	1,087,006	28,638	490,889	30.00
31.00	03100	INTENSIVE CARE UNIT	757,265	0	97,046	3,300	112,203	31.00
40.00	04000	SUBPROVIDER - IPF	789,069	0	220,477	2,906	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	301,176	0	202,219	1,492	149,604	50.00
51.00	05100	RECOVERY ROOM	77,812	0	14,275	521	18,701	51.00
53.00	05300	ANESTHESIOLOGY	15,607	0	9,532	0	102,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	418,227	0	134,160	690	0	54.00
54.01	03630	ULTRA SOUND	79,215	0	7,368	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	41,879	0	13,561	0	9,350	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	828,893	0	96,700	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,778	0	7,137	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	462,399	0	57,330	0	23,376	65.00
66.00	06600	PHYSICAL THERAPY	92,360	0	73,584	925	23,376	66.00
68.00	06800	SPEECH PATHOLOGY	771	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,191	0	33,223	756	42,076	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	370,204	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,529	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,699	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	144,040	0	6,562	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	1,355	0	6,631	0	0	90.01
91.00	09100	EMERGENCY	1,326,114	0	163,677	11,459	205,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,744,707	0	2,580,335	56,077	1,309,038	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	239	0	2,763	0	18,701	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	109,875	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	10,783	0	0	0	4,675	194.01
194.02	07952	MARKETING OTHER	28,681	0	0	0	4,675	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,894,285	0	2,583,098	56,077	1,337,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,567,788					10.00
11.00	01100	CAFETERIA	0	270,621				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	15,098	0	1,651,000		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,191	0	0	288,558	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,324	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,922	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,148,178	81,503	0	744,882	0	30.00
31.00	03100	INTENSIVE CARE UNIT	44,653	23,726	0	216,805	0	31.00
40.00	04000	SUBPROVIDER - IPF	374,957	25,684	0	234,758	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,821	0	89,782	0	50.00
51.00	05100	RECOVERY ROOM	0	2,738	0	24,963	0	51.00
53.00	05300	ANESTHESIOLOGY	0	535	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,052	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	1,652	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	20,146	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,499	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,536	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,014	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,809	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	284,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,246	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	37,187	0	339,810	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,567,788	262,437	0	1,651,000	288,558	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	6,012	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	642	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	1,530	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,567,788	270,621	0	1,651,000	288,558	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,903,858					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,077,560				16.00
17.00	01700	SOCIAL SERVICE	0	0	195,239			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	610,664	126,294	12,957,187	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	66,165	13,673	3,246,624	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	129,595	26,815	3,796,342	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	65,730	23,481	1,603,653	0	50.00
51.00	05100	RECOVERY ROOM	0	0	4,976	340,430	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	167,928	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,615,984	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	288,221	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	170,518	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	3,038,360	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	374,412	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,719,012	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	426,431	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,717	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	288,489	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	1,589,131	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,733	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,903,858	0	0	3,544,273	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	514,246	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	11,407	0	90.01
91.00	09100	EMERGENCY	0	205,406	0	5,637,260	0	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						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,903,858	1,077,560	195,239	41,356,358	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	22,306	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	0	393,277	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	43,323	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	107,294	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,903,858	1,077,560	195,239	41,922,558	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
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
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	FUND RAISING	194.01
194.02	07952	MARKETING OTHER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	1,690	581	2,271	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	103,874	68,826	175,008	347,708	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,992	49,099	1,833	55,924	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,918	0	4,918	8.00
9.00	00900	HOUSEKEEPING	0	15,765	0	15,765	9.00
10.00	01000	DIETARY	0	15,035	591	15,626	10.00
11.00	01100	CAFETERIA	0	13,939	436	14,375	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	5,803	8,330	14,133	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,720	1,215	9,935	14.00
15.00	01500	PHARMACY	33,440	8,322	144	41,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,218	1,052	4,270	16.00
17.00	01700	SOCIAL SERVICE	0	689	0	689	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,686	237,410	24,418	305,514	30.00
31.00	03100	INTENSIVE CARE UNIT	16,814	21,195	11,258	49,267	31.00
40.00	04000	SUBPROVIDER - IPF	0	48,154	12,427	60,581	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	44,166	39,259	83,425	50.00
51.00	05100	RECOVERY ROOM	0	3,118	1,406	4,524	51.00
53.00	05300	ANESTHESIOLOGY	0	2,082	13,582	15,664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,301	20,840	50,141	54.00
54.01	03630	ULTRA SOUND	0	1,609	9,862	11,471	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	2,962	0	2,962	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	26,921	21,120	3,297	51,338	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,559	895	2,454	63.00
65.00	06500	RESPIRATORY THERAPY	108,825	12,521	10,497	131,843	65.00
66.00	06600	PHYSICAL THERAPY	0	16,071	1,057	17,128	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,946	1,946	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,256	10,271	17,527	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,433	0	1,433	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	1,448	0	1,448	90.01
91.00	09100	EMERGENCY	8,512	35,748	1,689	45,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,064	683,177	351,894	1,382,135	2,247
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,503	603	0	40,106	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	2,489	2,489	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	386,567	683,780	354,383	1,424,730	2,271

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	348,133					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	21,451	0	77,472			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	279	0	675	5,872		8.00
9.00	00900	HOUSEKEEPING	10,460	0	2,165	564	29,026	9.00
10.00	01000	DIETARY	12,448	0	2,065	0	0	10.00
11.00	01100	CAFETERIA	1,562	0	1,914	0	406	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	13,287	0	797	0	203	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,719	0	1,197	0	812	14.00
15.00	01500	PHARMACY	23,643	0	1,143	0	406	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,366	0	442	0	913	16.00
17.00	01700	SOCIAL SERVICE	1,532	0	95	0	101	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	71,729	0	32,600	2,999	10,658	30.00
31.00	03100	INTENSIVE CARE UNIT	22,165	0	2,911	346	2,436	31.00
40.00	04000	SUBPROVIDER - IPF	23,096	0	6,613	304	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,815	0	6,065	156	3,248	50.00
51.00	05100	RECOVERY ROOM	2,278	0	428	55	406	51.00
53.00	05300	ANESTHESIOLOGY	457	0	286	0	2,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,242	0	4,024	72	0	54.00
54.01	03630	ULTRA SOUND	2,319	0	221	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	1,226	0	407	0	203	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	24,262	0	2,900	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,038	0	214	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	13,534	0	1,719	0	507	65.00
66.00	06600	PHYSICAL THERAPY	2,703	0	2,207	97	507	66.00
68.00	06800	SPEECH PATHOLOGY	23	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733	0	996	79	913	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,836	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,318	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,216	0	197	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	40	0	199	0	0	90.01
91.00	09100	EMERGENCY	38,816	0	4,909	1,200	4,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	343,755	0	77,389	5,872	28,418	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7	0	83	0	406	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	3,216	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	316	0	0	0	101	194.01
194.02	07952	MARKETING OTHER	839	0	0	0	101	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	348,133	0	77,472	5,872	29,026	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	30,212					10.00
11.00	01100	CAFETERIA	0	18,257				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,019	0	29,538		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	283	0	0	13,957	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	899	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	197	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,126	5,497	0	13,326	0	30.00
31.00	03100	INTENSIVE CARE UNIT	860	1,601	0	3,879	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,226	1,733	0	4,200	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	663	0	1,606	0	50.00
51.00	05100	RECOVERY ROOM	0	185	0	447	0	51.00
53.00	05300	ANESTHESIOLOGY	0	36	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	476	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	111	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,359	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	101	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	576	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	203	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	257	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	13,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	205	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	2,509	0	6,080	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,212	17,705	0	29,538	13,957	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	406	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	43	0	0	0	194.01
194.02	07952	MARKETING OTHER	0	103	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,212	18,257	0	29,538	13,957	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	67,098					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,937				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,625			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	8,466	1,697	475,089	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	917	184	84,734	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,796	361	106,066	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	911	316	105,254	0	50.00
51.00	05100	RECOVERY ROOM	0	0	67	8,407	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	18,678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	67,003	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	14,138	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	4,798	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	79,972	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,815	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	148,257	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	22,862	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,969	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21,516	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	24,588	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	367	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,098	0	0	72,416	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,846	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	1,687	0	90.01
91.00	09100	EMERGENCY	0	2,847	0	107,028	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,098	14,937	2,625	1,376,490	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	40,602	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	0	6,126	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	463	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	1,049	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,098	14,937	2,625	1,424,730	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
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
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	192.01
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	FUND RAISING	194.01
194.02	07952	MARKETING OTHER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	135,979					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		596,384				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	336	978	20,210,738			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,687	294,517	3,796,731	-11,894,285	30,028,273	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	9,764	3,084	867,371	0	1,850,220	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	978	0	0	0	24,038	8.00
9.00	00900	HOUSEKEEPING	3,135	0	643,914	0	902,168	9.00
10.00	01000	DIETARY	2,990	994	655,007	0	1,073,665	10.00
11.00	01100	CAFETERIA	2,772	734	0	0	134,731	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,154	14,018	888,310	0	1,146,034	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,734	2,044	98,066	0	148,301	14.00
15.00	01500	PHARMACY	1,655	242	0	0	2,039,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	640	1,770	423,549	0	721,598	16.00
17.00	01700	SOCIAL SERVICE	137	0	95,787	0	132,145	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,212	41,093	4,196,185	0	6,188,036	30.00
31.00	03100	INTENSIVE CARE UNIT	4,215	18,946	1,498,238	0	1,911,788	31.00
40.00	04000	SUBPROVIDER - IPF	9,576	20,914	1,395,164	0	1,992,081	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,783	66,069	434,290	0	760,348	50.00
51.00	05100	RECOVERY ROOM	620	2,366	155,830	0	196,444	51.00
53.00	05300	ANESTHESIOLOGY	414	22,857	15,749	0	39,401	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,827	35,071	429,560	0	1,055,855	54.00
54.01	03630	ULTRA SOUND	320	16,596	139,775	0	199,986	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	589	0	0	0	105,728	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,200	5,549	1,006,029	0	2,092,621	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	310	1,506	73,526	0	261,998	63.00
65.00	06500	RESPIRATORY THERAPY	2,490	17,666	695,833	0	1,167,371	65.00
66.00	06600	PHYSICAL THERAPY	3,196	1,779	147,328	0	233,172	66.00
68.00	06800	SPEECH PATHOLOGY	0	3,275	0	0	1,946	68.00
69.00	06900	ELECTROCARDIOLOGY	1,443	17,285	97,959	0	149,434	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	934,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	458,716	73.00
74.00	07400	RENAL DIALYSIS	285	0	0	0	363,644	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	288	0	0	0	3,421	90.01
91.00	09100	EMERGENCY	7,109	2,842	2,246,065	0	3,347,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,859	592,195	20,000,266	-11,894,285	29,650,649	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120	0	0	0	603	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	4,189	136,244	0	277,390	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	22,494	0	27,223	194.01
194.02	07952	MARKETING OTHER	0	0	51,734	0	72,408	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	683,780	354,383	2,630,811		11,894,285	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.028571	0.594219	0.130169		0.396103	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,271		348,133	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000112		0.011594	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	112,192				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	978	241,337			8.00
9.00	00900	HOUSEKEEPING	0	3,135	23,195	7,150		9.00
10.00	01000	DIETARY	0	2,990	0	0	45,609	10.00
11.00	01100	CAFETERIA	0	2,772	0	100	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,154	0	50	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,734	0	200	0	14.00
15.00	01500	PHARMACY	0	1,655	0	100	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	640	0	225	0	16.00
17.00	01700	SOCIAL SERVICE	0	137	0	25	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	47,212	123,257	2,625	33,402	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,215	14,203	600	1,299	31.00
40.00	04000	SUBPROVIDER - IPF	0	9,576	12,505	0	10,908	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,783	6,419	800	0	50.00
51.00	05100	RECOVERY ROOM	0	620	2,242	100	0	51.00
53.00	05300	ANESTHESIOLOGY	0	414	0	550	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,827	2,970	0	0	54.00
54.01	03630	ULTRA SOUND	0	320	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	589	0	50	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,200	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	310	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,490	0	125	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,196	3,979	125	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,443	3,253	225	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	285	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	288	0	0	0	90.01
91.00	09100	EMERGENCY	0	7,109	49,314	1,100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	112,072	241,337	7,000	45,609	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	120	0	100	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	0	0	0	25	0	194.01
194.02	07952	MARKETING OTHER	0	0	0	25	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	2,583,098	56,077	1,337,089	1,567,788	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	23.023905	0.232360	187.005455	34.374531	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	77,472	5,872	29,026	30,212	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.690531	0.024331	4.059580	0.662413	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	6.00	7.00	8.00	9.00	10.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	17,691					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	987	0	245,641			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	274	0	0	948,573		14.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	871	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	191	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,328	0	110,826	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,551	0	32,257	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,679	0	34,928	0	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	642	0	13,358	0	0	50.00
51.00	05100	RECOVERY ROOM	179	0	3,714	0	0	51.00
53.00	05300	ANESTHESIOLOGY	35	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	108	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,317	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	98	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	197	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	249	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	934,615	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,958	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,431	0	50,558	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
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,156	0	245,641	948,573	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	393	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	FUND RAISING	42	0	0	0	0	194.01
194.02	07952	MARKETING OTHER	100	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	270,621	0	1,651,000	288,558	2,903,858	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.297100	0.000000	6.721191	0.304202	29,038.580000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,257	0	29,538	13,957	67,098	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.031994	0.000000	0.120249	0.014714	670.980000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	11.00	12.00	13.00	14.00	15.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	131,150	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	74,324	30.00
31.00	03100	INTENSIVE CARE UNIT	8,053	31.00
40.00	04000	SUBPROVIDER - IPF	15,773	40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,000	50.00
51.00	05100	RECOVERY ROOM	0	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	03630	ULTRA SOUND	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE	0	90.01
91.00	09100	EMERGENCY	25,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,150	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES-CLINICS	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07951	FUND RAISING	0	194.01
194.02	07952	MARKETING OTHER	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,077,560	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.216241	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,937	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.113892	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
			48.314526	
			2,625	
			0.649592	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0181

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		16.00	17.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 11:51 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,957,187		12,957,187	0	12,957,187	30.00
31.00	03100	INTENSIVE CARE UNIT	3,246,624		3,246,624	0	3,246,624	31.00
40.00	04000	SUBPROVIDER - IPF	3,796,342		3,796,342	0	3,796,342	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,603,653		1,603,653	26,641	1,630,294	50.00
51.00	05100	RECOVERY ROOM	340,430		340,430	0	340,430	51.00
53.00	05300	ANESTHESIOLOGY	167,928		167,928	0	167,928	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,615,984		1,615,984	3,898	1,619,882	54.00
54.01	03630	ULTRA SOUND	288,221		288,221	0	288,221	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	170,518		170,518	0	170,518	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,038,360		3,038,360	32,075	3,070,435	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	374,412		374,412	0	374,412	63.00
65.00	06500	RESPIRATORY THERAPY	1,719,012	0	1,719,012	11,308	1,730,320	65.00
66.00	06600	PHYSICAL THERAPY	426,431	0	426,431	0	426,431	66.00
68.00	06800	SPEECH PATHOLOGY	2,717	0	2,717	0	2,717	68.00
69.00	06900	ELECTROCARDIOLOGY	288,489		288,489	0	288,489	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,589,131		1,589,131	0	1,589,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,733		23,733	0	23,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,544,273		3,544,273	0	3,544,273	73.00
74.00	07400	RENAL DIALYSIS	514,246		514,246	0	514,246	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CARE	11,407		11,407	0	11,407	90.01
91.00	09100	EMERGENCY	5,637,260		5,637,260	83,292	5,720,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,858,995		1,858,995		1,858,995	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,215,353	0	43,215,353	157,214	43,372,567	200.00
201.00		Less Observation Beds	1,858,995		1,858,995		1,858,995	201.00
202.00		Total (see instructions)	41,356,358	0	41,356,358	157,214	41,513,572	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 7/28/2022 11:51 am		
					Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
			Inpatient	Outpatient	Total (col. 6 + col. 7)						
			6.00	7.00	8.00						
			9.00			10.00					
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	28,378,909		28,378,909						30.00
31.00	03100	INTENSIVE CARE UNIT	11,106,944		11,106,944						31.00
40.00	04000	SUBPROVIDER - IPF	9,728,258		9,728,258						40.00
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	701,866	236,849	938,715	1.708349	0.000000				50.00
51.00	05100	RECOVERY ROOM	271,497	199,473	470,970	0.722827	0.000000				51.00
53.00	05300	ANESTHESIOLOGY	716,750	293,803	1,010,553	0.166174	0.000000				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,331,660	3,139,759	5,471,419	0.295350	0.000000				54.00
54.01	03630	ULTRA SOUND	439,899	428,705	868,604	0.331821	0.000000				54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000				55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000				56.00
57.00	05700	CT SCAN	4,585,821	8,483,022	13,068,843	0.013048	0.000000				57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000				58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000				59.00
60.00	06000	LABORATORY	13,787,700	10,426,094	24,213,794	0.125481	0.000000				60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,328,679	160,226	1,488,905	0.251468	0.000000				63.00
65.00	06500	RESPIRATORY THERAPY	6,998,659	720,078	7,718,737	0.222706	0.000000				65.00
66.00	06600	PHYSICAL THERAPY	354,940	93,570	448,510	0.950773	0.000000				66.00
68.00	06800	SPEECH PATHOLOGY	29,669	932	30,601	0.088788	0.000000				68.00
69.00	06900	ELECTROCARDIOLOGY	2,965,762	1,688,081	4,653,843	0.061989	0.000000				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,723,155	344,203	3,067,358	0.518078	0.000000				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,351	1,500	13,851	1.713450	0.000000				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,515,660	949,013	6,464,673	0.548252	0.000000				73.00
74.00	07400	RENAL DIALYSIS	1,159,502	107,094	1,266,596	0.406006	0.000000				74.00
OUTPATIENT SERVICE COST CENTERS											
90.00	09000	CLINIC	0	0	0	0.000000	0.000000				90.00
90.01	09001	WOUND CARE	74,018	182,706	256,724	0.044433	0.000000				90.01
91.00	09100	EMERGENCY	3,689,620	8,795,239	12,484,859	0.451528	0.000000				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	17,291	6,568,413	6,585,704	0.282277	0.000000				92.00
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE									113.00
200.00		Subtotal (see instructions)	96,918,610	42,818,760	139,737,370						200.00
201.00		Less Observation Beds									201.00
202.00		Total (see instructions)	96,918,610	42,818,760	139,737,370						202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 7/28/2022 11:51 am		
			Title XVIII		Hospital		PPS		
Cost Center Description			PPS Inpatient Ratio						
			11.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS							30.00
31.00	03100	INTENSIVE CARE UNIT							31.00
40.00	04000	SUBPROVIDER - IPF							40.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1.736729						50.00
51.00	05100	RECOVERY ROOM	0.722827						51.00
53.00	05300	ANESTHESIOLOGY	0.166174						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.296063						54.00
54.01	03630	ULTRA SOUND	0.331821						54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000						55.00
56.00	05600	RADIOISOTOPE	0.000000						56.00
57.00	05700	CT SCAN	0.013048						57.00
58.00	05800	MRI	0.000000						58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000						59.00
60.00	06000	LABORATORY	0.126805						60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.251468						63.00
65.00	06500	RESPIRATORY THERAPY	0.224171						65.00
66.00	06600	PHYSICAL THERAPY	0.950773						66.00
68.00	06800	SPEECH PATHOLOGY	0.088788						68.00
69.00	06900	ELECTROCARDIOLOGY	0.061989						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.518078						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.713450						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.548252						73.00
74.00	07400	RENAL DIALYSIS	0.406006						74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000						90.00
90.01	09001	WOUND CARE	0.044433						90.01
91.00	09100	EMERGENCY	0.458199						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282277						92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)							200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)							202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 11:51 am

				Title XIX		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	12,957,187		12,957,187	0	12,957,187	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,246,624		3,246,624	0	3,246,624	31.00	
40.00	04000	SUBPROVIDER - IPF	3,796,342		3,796,342	0	3,796,342	40.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,603,653		1,603,653	26,641	1,630,294	50.00	
51.00	05100	RECOVERY ROOM	340,430		340,430	0	340,430	51.00	
53.00	05300	ANESTHESIOLOGY	167,928		167,928	0	167,928	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,615,984		1,615,984	3,898	1,619,882	54.00	
54.01	03630	ULTRA SOUND	288,221		288,221	0	288,221	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00	
57.00	05700	CT SCAN	170,518		170,518	0	170,518	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	06000	LABORATORY	3,038,360		3,038,360	32,075	3,070,435	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	374,412		374,412	0	374,412	63.00	
65.00	06500	RESPIRATORY THERAPY	1,719,012	0	1,719,012	11,308	1,730,320	65.00	
66.00	06600	PHYSICAL THERAPY	426,431	0	426,431	0	426,431	66.00	
68.00	06800	SPEECH PATHOLOGY	2,717	0	2,717	0	2,717	68.00	
69.00	06900	ELECTROCARDIOLOGY	288,489		288,489	0	288,489	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,589,131		1,589,131	0	1,589,131	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,733		23,733	0	23,733	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,544,273		3,544,273	0	3,544,273	73.00	
74.00	07400	RENAL DIALYSIS	514,246		514,246	0	514,246	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	90.00	
90.01	09001	WOUND CARE	11,407		11,407	0	11,407	90.01	
91.00	09100	EMERGENCY	5,637,260		5,637,260	83,292	5,720,552	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,858,995		1,858,995		1,858,995	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	43,215,353	0	43,215,353	157,214	43,372,567	200.00	
201.00		Less Observation Beds	1,858,995		1,858,995		1,858,995	201.00	
202.00		Total (see instructions)	41,356,358	0	41,356,358	157,214	41,513,572	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 7/28/2022 11:51 am		
					Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
			Inpatient	Outpatient	Total (col. 6 + col. 7)						
			6.00	7.00	8.00						
			9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	24,291,707		24,291,707						30.00
31.00	03100	INTENSIVE CARE UNIT	4,885,802		4,885,802						31.00
40.00	04000	SUBPROVIDER - IPF	44,000		44,000						40.00
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	4,870,650	1,412,545	6,283,195	0.255229	0.000000				50.00
51.00	05100	RECOVERY ROOM	1,057,792	671,258	1,729,050	0.196888	0.000000				51.00
53.00	05300	ANESTHESIOLOGY	1,702,461	776,575	2,479,036	0.067739	0.000000				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	809,288	1,781,484	2,590,772	0.623746	0.000000				54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000				54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000				55.00
56.00	05600	RADIOISOTOPE	1,714,588	343,214	2,057,802	0.000000	0.000000				56.00
57.00	05700	CT SCAN	3,537,557	3,156,027	6,693,584	0.025475	0.000000				57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000				58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000				59.00
60.00	06000	LABORATORY	13,436,626	6,685,067	20,121,693	0.150999	0.000000				60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	715,286	64,292	779,578	0.480275	0.000000				63.00
65.00	06500	RESPIRATORY THERAPY	11,684,314	606,147	12,290,461	0.139866	0.000000				65.00
66.00	06600	PHYSICAL THERAPY	1,768,656	278,474	2,047,130	0.208307	0.000000				66.00
68.00	06800	SPEECH PATHOLOGY	78,334	11,752	90,086	0.030160	0.000000				68.00
69.00	06900	ELECTROCARDIOLOGY	2,308,963	619,783	2,928,746	0.098503	0.000000				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,372,362	1,201,230	3,573,592	0.444687	0.000000				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,727,730	684,753	9,412,483	0.376550	0.000000				73.00
74.00	07400	RENAL DIALYSIS	1,894,732	2,209	1,896,941	0.271092	0.000000				74.00
OUTPATIENT SERVICE COST CENTERS											
90.00	09000	CLINIC	0	0	0	0.000000	0.000000				90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000				90.01
91.00	09100	EMERGENCY	1,933,655	4,818,614	6,752,269	0.834869	0.000000				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,113,946	1,113,946	1.668838	0.000000				92.00
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE									113.00
200.00		Subtotal (see instructions)	87,834,503	24,227,370	112,061,873						200.00
201.00		Less Observation Beds									201.00
202.00		Total (see instructions)	87,834,503	24,227,370	112,061,873						202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 7/28/2022 11:51 am		
			Title XIX		Hospital		PPS		
Cost Center Description			PPS Inpatient Ratio						
			11.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS							30.00
31.00	03100	INTENSIVE CARE UNIT							31.00
40.00	04000	SUBPROVIDER - IPF							40.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.259469						50.00
51.00	05100	RECOVERY ROOM	0.196888						51.00
53.00	05300	ANESTHESIOLOGY	0.067739						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.625251						54.00
54.01	03630	ULTRA SOUND	0.000000						54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000						55.00
56.00	05600	RADIOISOTOPE	0.000000						56.00
57.00	05700	CT SCAN	0.025475						57.00
58.00	05800	MRI	0.000000						58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000						59.00
60.00	06000	LABORATORY	0.152593						60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.480275						63.00
65.00	06500	RESPIRATORY THERAPY	0.140786						65.00
66.00	06600	PHYSICAL THERAPY	0.208307						66.00
68.00	06800	SPEECH PATHOLOGY	0.030160						68.00
69.00	06900	ELECTROCARDIOLOGY	0.098503						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444687						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376550						73.00
74.00	07400	RENAL DIALYSIS	0.271092						74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000						90.00
90.01	09001	WOUND CARE	0.000000						90.01
91.00	09100	EMERGENCY	0.847204						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.668838						92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)							200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)							202.00

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

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,603,653	105,254	1,498,399	0	0
51.00	05100	RECOVERY ROOM	340,430	8,407	332,023	0	0
53.00	05300	ANESTHESIOLOGY	167,928	18,678	149,250	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,615,984	67,003	1,548,981	0	0
54.01	03630	ULTRA SOUND	288,221	14,138	274,083	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	170,518	4,798	165,720	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	3,038,360	79,972	2,958,388	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	374,412	5,815	368,597	0	0
65.00	06500	RESPIRATORY THERAPY	1,719,012	148,257	1,570,755	0	0
66.00	06600	PHYSICAL THERAPY	426,431	22,862	403,569	0	0
68.00	06800	SPEECH PATHOLOGY	2,717	1,969	748	0	0
69.00	06900	ELECTROCARDIOLOGY	288,489	21,516	266,973	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,589,131	24,588	1,564,543	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,733	367	23,366	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,544,273	72,416	3,471,857	0	0
74.00	07400	RENAL DIALYSIS	514,246	5,846	508,400	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CARE	11,407	1,687	9,720	0	0
91.00	09100	EMERGENCY	5,637,260	107,028	5,530,232	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,858,995	68,162	1,790,833	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (sum of lines 50 thru 199)	23,215,200	778,763	22,436,437	0	0
201.00		Less Observation Beds	1,858,995	68,162	1,790,833	0	0
202.00		Total (line 200 minus line 201)	21,356,205	710,601	20,645,604	0	0

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

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,603,653	938,715	1.708349	50.00
51.00	05100	RECOVERY ROOM	340,430	470,970	0.722827	51.00
53.00	05300	ANESTHESIOLOGY	167,928	1,010,553	0.166174	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,615,984	5,471,419	0.295350	54.00
54.01	03630	ULTRA SOUND	288,221	868,604	0.331821	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	170,518	13,068,843	0.013048	57.00
58.00	05800	MRI	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,038,360	24,213,794	0.125481	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	374,412	1,488,905	0.251468	63.00
65.00	06500	RESPIRATORY THERAPY	1,719,012	7,718,737	0.222706	65.00
66.00	06600	PHYSICAL THERAPY	426,431	448,510	0.950773	66.00
68.00	06800	SPEECH PATHOLOGY	2,717	30,601	0.088788	68.00
69.00	06900	ELECTROCARDIOLOGY	288,489	4,653,843	0.061989	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,589,131	3,067,358	0.518078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,733	13,851	1.713450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,544,273	6,464,673	0.548252	73.00
74.00	07400	RENAL DIALYSIS	514,246	1,266,596	0.406006	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	90.00
90.01	09001	WOUND CARE	11,407	256,724	0.044433	90.01
91.00	09100	EMERGENCY	5,637,260	12,484,859	0.451528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,858,995	6,585,704	0.282277	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	23,215,200	90,523,259		200.00
201.00		Less Observation Beds	1,858,995	0		201.00
202.00		Total (line 200 minus line 201)	21,356,205	90,523,259		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/28/2022 11:51 am

Title XVIII			Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	475,089	0	475,089	12,999	36.55	30.00
31.00	INTENSIVE CARE UNIT	84,734		84,734	866	97.85	31.00
40.00	SUBPROVIDER - IPF	106,066	0	106,066	3,636	29.17	40.00
200.00	Total (lines 30 through 199)	665,889		665,889	17,501		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	4,617	168,751				30.00
31.00	INTENSIVE CARE UNIT	441	43,152				31.00
40.00	SUBPROVIDER - IPF	1,156	33,721				40.00
200.00	Total (lines 30 through 199)	6,214	245,624				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	105,254	938,715	0.112126	280,011	31,397 50.00
51.00	05100	RECOVERY ROOM	8,407	470,970	0.017850	80,608	1,439 51.00
53.00	05300	ANESTHESIOLOGY	18,678	1,010,553	0.018483	311,111	5,750 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,003	5,471,419	0.012246	720,029	8,817 54.00
54.01	03630	ULTRA SOUND	14,138	868,604	0.016277	141,459	2,303 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0 56.00
57.00	05700	CT SCAN	4,798	13,068,843	0.000367	1,232,043	452 57.00
58.00	05800	MRI	0	0	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	79,972	24,213,794	0.003303	4,244,906	14,021 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,815	1,488,905	0.003906	399,158	1,559 63.00
65.00	06500	RESPIRATORY THERAPY	148,257	7,718,737	0.019207	2,049,407	39,363 65.00
66.00	06600	PHYSICAL THERAPY	22,862	448,510	0.050973	135,176	6,890 66.00
68.00	06800	SPEECH PATHOLOGY	1,969	30,601	0.064344	10,344	666 68.00
69.00	06900	ELECTROCARDIOLOGY	21,516	4,653,843	0.004623	1,014,345	4,689 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,588	3,067,358	0.008016	404,823	3,245 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	367	13,851	0.026496	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,416	6,464,673	0.011202	1,634,814	18,313 73.00
74.00	07400	RENAL DIALYSIS	5,846	1,266,596	0.004616	453,895	2,095 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
90.01	09001	WOUND CARE	1,687	256,724	0.006571	20,565	135 90.01
91.00	09100	EMERGENCY	107,028	12,484,859	0.008573	767,347	6,578 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,162	6,585,704	0.010350	11,972	124 92.00
200.00		Total (lines 50 through 199)	778,763	90,523,259		13,912,013	147,836 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/28/2022 11:51 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00		
200.00		Total (lines 30 through 199)	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	12,999	0.00	4,617	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	866	0.00	441	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,636	0.00	1,156	40.00		
200.00		Total (lines 30 through 199)		0	17,501		6,214	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	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	03630	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0181

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 11:51 am

				Title XVIII		Hospital	PPS	
	Cost Center Description		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	938,715	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	470,970	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,010,553	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,471,419	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	868,604	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	13,068,843	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	24,213,794	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,488,905	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,718,737	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	448,510	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	30,601	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,653,843	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,067,358	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,851	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,464,673	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,266,596	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	256,724	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	12,484,859	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,585,704	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	90,523,259		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	280,011	0	47,655	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	80,608	0	20,060	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	311,111	0	25,577	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	720,029	0	280,860	0	54.00
54.01	03630	ULTRA SOUND	0.000000	141,459	0	48,797	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	1,232,043	0	763,717	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,244,906	0	785,553	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	399,158	0	18,656	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,049,407	0	29,332	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	135,176	0	3,184	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,344	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,014,345	0	229,170	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	404,823	0	13,780	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	803	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,634,814	0	79,525	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	453,895	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	20,565	0	2,021	0	90.01
91.00	09100	EMERGENCY	0.000000	767,347	0	625,248	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	11,972	0	630,569	0	92.00
200.00		Total (lines 50 through 199)		13,912,013	0	3,604,507	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 7/28/2022 11:51 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1.708349	47,655	0	0	81,411	50.00
51.00	05100	RECOVERY ROOM	0.722827	20,060	0	0	14,500	51.00
53.00	05300	ANESTHESIOLOGY	0.166174	25,577	0	0	4,250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.295350	280,860	0	0	82,952	54.00
54.01	03630	ULTRA SOUND	0.331821	48,797	0	0	16,192	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.013048	763,717	0	0	9,965	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.125481	785,553	408	0	98,572	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.251468	18,656	0	0	4,691	63.00
65.00	06500	RESPIRATORY THERAPY	0.222706	29,332	0	0	6,532	65.00
66.00	06600	PHYSICAL THERAPY	0.950773	3,184	0	0	3,027	66.00
68.00	06800	SPEECH PATHOLOGY	0.088788	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061989	229,170	0	0	14,206	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.518078	13,780	0	0	7,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.713450	803	0	0	1,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.548252	79,525	0	0	43,600	73.00
74.00	07400	RENAL DIALYSIS	0.406006	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.044433	2,021	0	0	90	90.01
91.00	09100	EMERGENCY	0.451528	625,248	0	0	282,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282277	630,569	0	0	177,995	92.00
200.00		Subtotal (see instructions)		3,604,507	408	0	848,815	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,604,507	408	0	848,815	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 7/28/2022 11:51 am
			Title XVIII		Hospital	PPS
Cost Center Description		Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	51	0		60.00
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
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
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
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)	51	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	51	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:

Worksheet D

Component CCN: 14-S181

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
7/28/2022 11:51 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	105,254	938,715	0.112126	193	22	50.00
51.00	05100	RECOVERY ROOM	8,407	470,970	0.017850	0	0	51.00
53.00	05300	ANESTHESIOLOGY	18,678	1,010,553	0.018483	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,003	5,471,419	0.012246	47,276	579	54.00
54.01	03630	ULTRA SOUND	14,138	868,604	0.016277	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	4,798	13,068,843	0.000367	22,060	8	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	79,972	24,213,794	0.003303	486,189	1,606	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,815	1,488,905	0.003906	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	148,257	7,718,737	0.019207	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,862	448,510	0.050973	334	17	66.00
68.00	06800	SPEECH PATHOLOGY	1,969	30,601	0.064344	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,516	4,653,843	0.004623	59,939	277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,588	3,067,358	0.008016	5,464	44	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	367	13,851	0.026496	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,416	6,464,673	0.011202	138,589	1,552	73.00
74.00	07400	RENAL DIALYSIS	5,846	1,266,596	0.004616	6,108	28	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE	1,687	256,724	0.006571	0	0	90.01
91.00	09100	EMERGENCY	107,028	12,484,859	0.008573	243,697	2,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,585,704	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	710,601	90,523,259		1,009,849	6,222	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/28/2022 11:51 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
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	03630	ULTRA SOUND		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
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
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
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	WOUND CARE		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/28/2022 11:51 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	938,715	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	470,970	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	1,010,553	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	5,471,419	0.000000	54.00
54.01	03630	ULTRA SOUND		0	0	0	868,604	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	13,068,843	0.000000	57.00
58.00	05800	MRI		0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	24,213,794	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	1,488,905	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	7,718,737	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	448,510	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	30,601	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,653,843	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	3,067,358	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	13,851	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	6,464,673	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	1,266,596	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE		0	0	0	256,724	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	12,484,859	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	6,585,704	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	90,523,259		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 7/28/2022 11:51 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	193	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	47,276	0	1,429	0	54.00
54.01	03630	ULTRA SOUND		0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	22,060	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	486,189	0	5,085	0	60.00
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	334	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	59,939	0	1,235	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	5,464	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	138,589	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	6,108	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE		0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY		0.000000	243,697	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)			1,009,849	0	7,749	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0181

Period:

Worksheet D

Component CCN: 14-S181

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
7/28/2022 11:51 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1.708349	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.722827	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.166174	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.295350	1,429	0	0	54.00
54.01	03630 ULTRA SOUND	0.331821	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700 CT SCAN	0.013048	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.125481	5,085	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.251468	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.222706	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.950773	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.088788	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.061989	1,235	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.518078	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.713450	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548252	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.406006	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	90.00
90.01	09001 WOUND CARE	0.044433	0	0	0	90.01
91.00	09100 EMERGENCY	0.451528	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.282277	0	0	0	92.00
200.00	Subtotal (see instructions)		7,749	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		7,749	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0181 Component CCN: 14-S181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 7/28/2022 11:51 am		
			Title XVIII		Subprovider - IPF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	03630	ULTRA SOUND	0	0					54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
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
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
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
90.01	09001	WOUND CARE	0	0					90.01
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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/28/2022 11:51 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	475,089	0	475,089	12,999	36.55	30.00
31.00	INTENSIVE CARE UNIT	84,734		84,734	866	97.85	31.00
40.00	SUBPROVIDER - IPF	106,066	0	106,066	3,636	29.17	40.00
200.00	Total (lines 30 through 199)	665,889		665,889	17,501		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	336	12,281				30.00
31.00	INTENSIVE CARE UNIT	130	12,721				31.00
40.00	SUBPROVIDER - IPF	40	1,167				40.00
200.00	Total (lines 30 through 199)	506	26,169				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	105,254	6,283,195	0.016752	0	50.00
51.00	05100	RECOVERY ROOM	8,407	1,729,050	0.004862	0	51.00
53.00	05300	ANESTHESIOLOGY	18,678	2,479,036	0.007534	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,003	2,590,772	0.025862	0	54.00
54.01	03630	ULTRA SOUND	14,138	0	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	2,057,802	0.000000	0	56.00
57.00	05700	CT SCAN	4,798	6,693,584	0.000717	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	59.00
60.00	06000	LABORATORY	79,972	20,121,693	0.003974	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,815	779,578	0.007459	0	63.00
65.00	06500	RESPIRATORY THERAPY	148,257	12,290,461	0.012063	0	65.00
66.00	06600	PHYSICAL THERAPY	22,862	2,047,130	0.011168	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,969	90,086	0.021857	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,516	2,928,746	0.007346	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,588	3,573,592	0.006880	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	367	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,416	9,412,483	0.007694	0	73.00
74.00	07400	RENAL DIALYSIS	5,846	1,896,941	0.003082	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	90.00
90.01	09001	WOUND CARE	1,687	0	0.000000	0	90.01
91.00	09100	EMERGENCY	107,028	6,752,269	0.015851	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,162	1,113,946	0.061190	0	92.00
200.00		Total (lines 50 through 199)	778,763	82,840,364		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0181		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/28/2022 11:51 am	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	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	
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	12,999	0.00	336	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	866	0.00	130	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	3,636	0.00	40	40.00		
200.00		Total (lines 30 through 199)		0	17,501		506	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	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0181

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

Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	03630	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 11:51 am

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	6,283,195	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,729,050	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,479,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,590,772	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,057,802	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	6,693,584	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	20,121,693	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	779,578	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,290,461	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,047,130	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	90,086	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,928,746	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,573,592	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,412,483	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,896,941	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,752,269	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,113,946	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	82,840,364		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
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	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 11:51 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,999	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,999	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)			11,134	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)			4,617	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)			12,957,187	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)			12,957,187	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)			12,957,187	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)			996.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,602,133	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)			4,602,133	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,246,624	866	3,748.99	441	1,653,305	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						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,809,038	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,064,476	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)					211,903	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					147,836	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					359,739	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,704,737	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)					1,865	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					996.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,858,995	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 11:51 am

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	475,089	12,957,187	0.036666	1,858,995	68,162
91.00	Nursing Program cost	0	12,957,187	0.000000	1,858,995	0
92.00	Allied health cost	0	12,957,187	0.000000	1,858,995	0
93.00	All other Medical Education	0	12,957,187	0.000000	1,858,995	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 11:51 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,636	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,636	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,636	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)		1,156	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)		3,796,342	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)		3,796,342	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)		3,796,342	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)		1,044.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,206,980	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)		1,206,980	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 11:51 am	
				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)						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						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					273,260	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,480,240	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)					33,721	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,222	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					39,943	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,440,297	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: 14-0181 Component CCN: 14-S181		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 11:51 am	
		Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	106,066	3,796,342	0.027939	0	0 90.00
91.00	Nursing Program cost	0	3,796,342	0.000000	0	0 91.00
92.00	Allied health cost	0	3,796,342	0.000000	0	0 92.00
93.00	All other Medical Education	0	3,796,342	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 11:51 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,999	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,999	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)		11,134	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)		336	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)		12,957,187	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)		12,957,187	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)		12,957,187	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)		996.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		334,918	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)		334,918	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XIX		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,246,624	866	3,748.99	130	487,369	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						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)					822,287	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)					25,002	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)					25,002	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					797,285	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)					1,865	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					996.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,858,995	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0181

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	475,089	12,957,187	0.036666	1,858,995	68,162
91.00	Nursing Program cost	0	12,957,187	0.000000	1,858,995	0
92.00	Allied health cost	0	12,957,187	0.000000	1,858,995	0
93.00	All other Medical Education	0	12,957,187	0.000000	1,858,995	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/28/2022 11:51 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		11,955,360		30.00
31.00	03100	INTENSIVE CARE UNIT		3,318,794		31.00
40.00	04000	SUBPROVIDER - IPF		71,944		40.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.736729	280,011	486,303	50.00
51.00	05100	RECOVERY ROOM	0.722827	80,608	58,266	51.00
53.00	05300	ANESTHESIOLOGY	0.166174	311,111	51,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.296063	720,029	213,174	54.00
54.01	03630	ULTRA SOUND	0.331821	141,459	46,939	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.013048	1,232,043	16,076	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.126805	4,244,906	538,275	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.251468	399,158	100,375	63.00
65.00	06500	RESPIRATORY THERAPY	0.224171	2,049,407	459,418	65.00
66.00	06600	PHYSICAL THERAPY	0.950773	135,176	128,522	66.00
68.00	06800	SPEECH PATHOLOGY	0.088788	10,344	918	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061989	1,014,345	62,878	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.518078	404,823	209,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.713450	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.548252	1,634,814	896,290	73.00
74.00	07400	RENAL DIALYSIS	0.406006	453,895	184,284	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0.044433	20,565	914	90.01
91.00	09100	EMERGENCY	0.458199	767,347	351,598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.282277	11,972	3,379	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,912,013	3,809,038	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)		13,912,013		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/28/2022 11:51 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		3,033,750		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.736729	193	335	50.00
51.00	05100 RECOVERY ROOM	0.722827	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.166174	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.296063	47,276	13,997	54.00
54.01	03630 ULTRA SOUND	0.331821	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.013048	22,060	288	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.126805	486,189	61,651	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.251468	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.224171	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.950773	334	318	66.00
68.00	06800 SPEECH PATHOLOGY	0.088788	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.061989	59,939	3,716	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.518078	5,464	2,831	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.713450	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.548252	138,589	75,982	73.00
74.00	07400 RENAL DIALYSIS	0.406006	6,108	2,480	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CARE	0.044433	0	0	90.01
91.00	09100 EMERGENCY	0.458199	243,697	111,662	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.282277	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,009,849	273,260	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,009,849		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/28/2022 11:51 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,636,708		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		910,048		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)		399,928		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		157,166		2.04
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		116.89		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		19.37		30.00
31.00	Percentage of Medicaid patient days (see instructions)		35.94		31.00
32.00	Sum of lines 30 and 31		55.31		32.00
33.00	Allowable disproportionate share percentage (see instructions)		34.85		33.00
34.00	Disproportionate share adjustment (see instructions)		396,136		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/28/2022 11:51 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,290,014,521	7,192,008,710
35.01	Factor 3 (see instructions)		0.000076132	0.000074191
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		631,131	533,582
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		472,051	134,492
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		606,543	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		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 (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	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		6,106,529	
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)		6,106,529	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		401,139	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		45,319	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,552,987	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,552,987	61.00
62.00	Deductibles billed to program beneficiaries		504,692	62.00
63.00	Coinsurance billed to program beneficiaries		99,999	63.00
64.00	Allowable bad debts (see instructions)		328,209	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		213,336	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		135,159	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,161,632	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-36,875	70.93
70.94	HRR adjustment amount (see instructions)		-1,560	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/28/2022 11:51 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		65,146	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,058,051	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		6,908,347	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)		-850,296	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		275,041	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2022 11:51 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,636,708	0	3,636,708		3,636,708	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	910,048	0		910,048	910,048	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	399,928	0	399,928		399,928	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	157,166	0		157,166	157,166	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	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	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3485	0.3485	0.3485	0.3485		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	396,136	0	316,848	79,288	396,136	11.00
11.01	Uncompensated care payments	36.00	606,543	0	1,351,240	407,345	1,758,585	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	6,106,529	0	4,552,682	1,553,847	6,106,529	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	6,106,529	0	4,552,682	1,553,847	6,106,529	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	401,139	0	319,439	81,700	401,139	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2022 11:51 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	45,319	0	43,177	2,141	45,318
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	4,915,298	1,637,688	6,552,986
		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	348,076	0	278,770	69,306	348,076
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	11,816	0	7,635	4,181	11,816
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1185	0.1185	0.1185	0.1185	
25.00	Disproportionate share adjustment (see instructions)	11.00	41,247	0	33,034	8,213	41,247
26.00	Total prospective capital payments (see instructions)	12.00	401,139	0	319,439	81,700	401,139
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2022 11:51 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,636,708	3,636,708		3,636,708	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	910,048		910,048	910,048	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	399,928	399,928		399,928	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	157,166		157,166	157,166	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3485	0.3485	0.3485		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	396,136	316,848	79,288	396,136	11.00
11.01	Uncompensated care payments	36.00	606,543	472,051	134,492	606,543	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,106,529	4,825,535	1,280,994	6,106,529	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,106,529	4,825,535	1,280,994	6,106,529	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	401,139	319,439	81,700	401,139	16.00
17.00	Special add-on payments for new technologies	54.00	45,319	43,178	2,141	45,319	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,188,152	1,364,835	6,552,987	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2022 11:51 am

		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	348,076	278,770	69,306	348,076	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	11,816	7,635	4,181	11,816	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1185	0.1185	0.1185		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	41,247	33,034	8,213	41,247	25.00
26.00	Total prospective capital payments (see instructions)	12.00	401,139	319,439	81,700	401,139	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-36,875	-36,875	0	-36,875	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	-1,560	-1,104	-456	-1,560	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		51,502	13,644	65,146	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems		SOUTH SHORE HOSPITAL CORPORATION		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/28/2022 11:51 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			51	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			848,815	2.00
3.00	OPPS payments			309,848	3.00
4.00	Outlier payment (see instructions)			66,893	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			51	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			408	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)			408	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)			408	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			357	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)			51	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)			376,741	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			71,016	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)			305,776	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)			305,776	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			305,776	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)			51,574	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			33,523	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			42,782	36.00
37.00	Subtotal (see instructions)			339,299	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			339,299	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			305,726	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)			33,573	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: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part B
Date/Time Prepared:
7/28/2022 11:51 am

Title XVIII

Hospital

PPS

1.00

MEDICARE PART B ANCILLARY COSTS

200.00 Part B Combined Billed Days

0 200.00

Health Financial Systems		SOUTH SHORE HOSPITAL CORPORATION		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181	Period: From 01/01/2021	Worksheet E	
		Component CCN: 14-S181	To 12/31/2021	Part B	
		Title XVIII	Subprovider - IPF	Date/Time Prepared: 7/28/2022 11:51 am	
				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)			1,137	2.00
3.00	OPPS payments			165	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			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)			33	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)			132	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)			132	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			132	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)			132	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)			132	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			132	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)			0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/28/2022 11:51 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
7/28/2022 11:51 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		587,741		305,726	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		6,332,793		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	05/12/2021	12,187		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)		-12,187		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)		6,908,347		305,726	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		33,573	6.01	
6.02	SETTLEMENT TO PROGRAM		850,296		0	6.02	
7.00	Total Medicare program liability (see instructions)		6,058,051		339,299	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: 14-0181

Period:

Worksheet E-1

Component CCN: 14-S181

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
7/28/2022 11:51 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,023,609		132	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,023,609		132	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		52,610		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,076,219		132	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: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part II
Date/Time Prepared:
7/28/2022 11:51 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0181 Component CCN: 14-S181	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 7/28/2022 11:51 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,145,221	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		9.961644	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,145,221	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,145,221	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,145,221	18.00
19.00	Deductibles		106,772	19.00
20.00	Subtotal (line 18 minus line 19)		1,038,449	20.00
21.00	Coinsurance		14,840	21.00
22.00	Subtotal (line 20 minus line 21)		1,023,609	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		80,938	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		52,610	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		78,122	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,076,219	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.98	Recovery of accelerated depreciation.		0	30.98
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,076,219	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		1,023,609	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)		52,610	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

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

Provider CCN: 14-0181

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

Worksheet G

Date/Time Prepared:
7/28/2022 11:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,316,869	0	0	0	1.00
2.00	Temporary investments	400,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,480,678	0	0	0	4.00
5.00	Other receivable	336,616	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	522,096	0	0	0	7.00
8.00	Prepaid expenses	388,080	0	0	0	8.00
9.00	Other current assets	14,621	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,458,960	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,428,579	0	0	0	12.00
13.00	Land improvements	1,100,274	0	0	0	13.00
14.00	Accumulated depreciation	-1,101,120	0	0	0	14.00
15.00	Buildings	18,021,431	0	0	0	15.00
16.00	Accumulated depreciation	-12,350,672	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	10,799,771	0	0	0	19.00
20.00	Accumulated depreciation	-10,343,221	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	23,118,723	0	0	0	23.00
24.00	Accumulated depreciation	-22,183,488	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)	8,490,277	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	242,044	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	242,044	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,191,281	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,763,624	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,763,624	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	6,842,323	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,842,323	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,605,947	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,585,334				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)	5,585,334	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,191,281	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0181

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

Worksheet G-1

Date/Time Prepared:
7/28/2022 11:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,510,856		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,074,478				2.00
3.00	Total (sum of line 1 and line 2)		5,585,334		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,585,334		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,585,334		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0181

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2022 11:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	28,378,909		28,378,909	1.00
2.00	SUBPROVIDER - IPF	9,728,258		9,728,258	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,107,167		38,107,167	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,106,944		11,106,944	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				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,106,944		11,106,944	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,214,111		49,214,111	17.00
18.00	Ancillary services	43,924,470	27,271,946	71,196,416	18.00
19.00	Outpatient services	3,780,928	15,546,357	19,327,285	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	96,919,509	42,818,303	139,737,812	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,020,778		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,020,778		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0181

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

Worksheet G-3

Date/Time Prepared:
7/28/2022 11:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	139,737,812	1.00
2.00	Less contractual allowances and discounts on patients' accounts	104,949,059	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,788,753	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,020,778	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,232,025	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	411,702	24.00
24.01	INVESTMENT IN BETTER HEALTH	6,700,000	24.01
24.02	UNREALIZED GAINS & LOSSES	4,194,800	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	11,306,502	25.00
26.00	Total (line 5 plus line 25)	1,074,477	26.00
27.00	ROUNDING	-1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,074,478	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0181	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 7/28/2022 11:51 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		348,076	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		11,816	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)		32.88	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		19.37	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		35.94	8.00
9.00	Sum of lines 7 and 8		55.31	9.00
10.00	Allowable disproportionate share percentage (see instructions)		11.85	10.00
11.00	Disproportionate share adjustment (see instructions)		41,247	11.00
12.00	Total prospective capital payments (see instructions)		401,139	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