

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: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/29/2021 5:15 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/29/2021	Time: 5:15 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEARTLAND REGIONAL MEDICAL CENTER (14-0184) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) GAY HUFF
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-908	-139,273	0	0	1.00
2.00	Subprovider - IPF	0	0	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	-908	-139,273	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.

Health Financial Systems		HEARTLAND REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0184	
				Period: From 05/01/2020 To 04/30/2021	
				Worksheet S-2 Part I Date/Time Prepared: 9/29/2021 5:15 pm	
1.00		2.00		3.00	
Hospital and Hospital Health Care Complex Address:					
1.00 Street: 917 WEST MAIN ST		PO Box:		1.00	
2.00 City: MARION		State: IL		2.00	
		Zip Code: 62959		County: WILLIAMSON	
		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		9.00	
Hospital and Hospital-Based Component Identification:					
3.00 Hospital		HEARTLAND REGIONAL MEDICAL CENTER		140184	16060
4.00 Subprovider - IPF				1	07/01/1996
5.00 Subprovider - IRF					N
6.00 Subprovider - (Other)					P
7.00 Swing Beds - SNF		HEARTLAND REGIONAL MEDICAL CENTER		14U184	16060
8.00 Swing Beds - NF					03/23/1999
9.00 Hospital-Based SNF					N
10.00 Hospital-Based NF					P
11.00 Hospital-Based OLTC					N
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)				05/01/2020	04/30/2021
21.00 Type of Control (see instructions)				4	
				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	
22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)		Y		Y	
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.		N		N	
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.		N		N	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		3		N	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid
		1.00	2.00	3.00	4.00
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.		153	0	0	0
		5.00	6.00	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
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	46.00
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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		56.00
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.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

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

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Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

	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						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	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)					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.			N 86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N 87.00			
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N Y 90.00			
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N N 91.00			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00			
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N N 93.00			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N N 94.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 95.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N N 96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 97.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.00			
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.01			
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.02			
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.03			
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.04			
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.05			
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y Y 98.06			
Rural Providers							
105.00	Does this hospital qualify as a CAH?			N 105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00			
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00			
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			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/29/2021 5:15 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	214,809	24,732	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/29/2021 5:15 pm
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1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: QUORUM HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 10101		141.00
142.00	Street: 1573 MALLORY LANE	PO Box:				142.00
143.00	City: BRENTWOOD	State: TN		Zip Code: 37027		143.00
						1.00
144.00 Are provider based physicians' costs included in Worksheet A?						Y
						1.00
						2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00
						1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	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
		0	1.00	2.00	3.00	4.00
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: 14-0184		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part II Date/Time Prepared: 9/29/2021 5:15 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	08/17/2021	Y	08/17/2021
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	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part II Date/Time Prepared: 9/29/2021 5:15 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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		Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2020
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.	CLINTON	BALLEW	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH CORP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3869	CBALLEW@QHCUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT	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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	76	27,740	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		76	27,740	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	6,570	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		94	34,310	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						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)		94			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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,675	133	5,590			1.00
2.00	HMO and other (see instructions)	464	776				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,675	133	5,590			7.00
8.00	INTENSIVE CARE UNIT	312	20	1,187			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	2,987	153	6,777	0.00	242.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						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	242.40	27.00
28.00	Observation Bed Days		0	1,434			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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	922	53	1,892	1.00
2.00 HMO and other (see instructions)			131	267		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	922	53	1,892	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	18,268,361	0	18,268,361	504,187.00	36.23
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)		85,746	26,453	112,199	2,751.00	40.78
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		596,592	0	596,592	14,286.00	41.76
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		128,351	0	128,351	714.00	179.76
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,017,907	0	1,017,907	13,113.00	77.63
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)		4,366,673	0	4,366,673		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		25,575	0	25,575		
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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	303,591	0	303,591	7,625.00	39.82	26.00
27.00	Administrative & General	5.00	2,496,561	-106,308	2,390,253	55,391.00	43.15	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	329,382	0	329,382	11,582.00	28.44	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		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	1,121,190	0	1,121,190	23,937.00	46.84	38.00
39.00	Central Services and Supply	14.00	233,813	0	233,813	12,679.00	18.44	39.00
40.00	Pharmacy	15.00	961,632	0	961,632	20,510.00	46.89	40.00
41.00	Medical Records & Medical Records Library	16.00	43,421	0	43,421	1,437.00	30.22	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part III
Date/Time Prepared:
9/29/2021 5:15 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	18,268,361	0	18,268,361	504,187.00	36.23	1.00
2.00	Excluded area salaries (see instructions)	85,746	26,453	112,199	2,751.00	40.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	18,182,615	-26,453	18,156,162	501,436.00	36.21	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,742,850	0	1,742,850	28,113.00	61.99	4.00
5.00	Subtotal wage-related costs (see inst.)	4,366,673	0	4,366,673	0.00	24.05	5.00
6.00	Total (sum of lines 3 thru 5)	24,292,138	-26,453	24,265,685	529,549.00	45.82	6.00
7.00	Total overhead cost (see instructions)	5,489,590	-106,308	5,383,282	133,161.00	40.43	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
9/29/2021 5:15 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	289,297	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,288,823	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	12,213	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,873	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-378	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	10,076	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	339,063	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	1,065,789	17.00
18.00	Medicare Taxes - Employers Portion Only	249,257	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	116,534	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,382,547	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: 14-0184

 Period:
 From 05/01/2020
 To 04/30/2021

 Worksheet S-3
 Part V
 Date/Time Prepared:
 9/29/2021 5:15 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	596,592	4,382,547	1.00
2.00	Hospital	596,592	4,382,547	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		HEARTLAND REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet S-10 Date/Time Prepared: 9/29/2021 5:15 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.120131	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			13,915,279	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			9,603,239	5.00
6.00	Medicaid charges			105,743,316	6.00
7.00	Medicaid cost (line 1 times line 6)			12,703,050	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)	4,556,513	1,305	4,557,818	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	547,378	1,305	548,683	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	547,378	1,305	548,683	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)			7,526,513	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			333,403	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			512,928	27.01
28.00	Non-Medicare bad debt expense (see instructions)			7,013,585	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,022,074	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,570,757	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,570,757	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,375,845	1,375,845	1,230,352	2,606,197	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,453,159	2,453,159	10,531	2,463,690	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	303,591	76,573	380,164	2,960,290	3,340,454	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,496,561	25,092,051	27,588,612	-4,540,947	23,047,665	5.00
7.00	00700	OPERATION OF PLANT	329,382	2,539,209	2,868,591	-16,520	2,852,071	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	220,833	220,833	0	220,833	8.00
9.00	00900	HOUSEKEEPING	0	1,156,060	1,156,060	0	1,156,060	9.00
10.00	01000	DIETARY	0	1,303,088	1,303,088	-712,877	590,211	10.00
11.00	01100	CAFETERIA	0	0	0	712,877	712,877	11.00
13.00	01300	NURSING ADMINISTRATION	1,121,190	332,315	1,453,505	0	1,453,505	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233,813	4,127,467	4,361,280	-3,827,053	534,227	14.00
15.00	01500	PHARMACY	961,632	2,041,057	3,002,689	-1,686,817	1,315,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,421	56,378	99,799	0	99,799	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,415,046	1,959,007	4,374,053	-135,494	4,238,559	30.00
31.00	03100	INTENSIVE CARE UNIT	1,050,365	1,116,948	2,167,313	0	2,167,313	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,159,144	2,855,933	5,015,077	555,884	5,570,961	50.00
51.00	05100	RECOVERY ROOM	509,278	47,190	556,468	-556,468	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,427,662	2,427,662	0	2,427,662	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	877,939	1,008,078	1,886,017	0	1,886,017	54.00
54.01	05401	ULTRASOUND	107,326	112,932	220,258	0	220,258	54.01
56.00	05600	RADIOISOTOPE	194,388	148,692	343,080	0	343,080	56.00
57.00	05700	CT SCAN	298,302	150,623	448,925	0	448,925	57.00
58.00	05800	MRI	103,729	73,418	177,147	0	177,147	58.00
60.00	06000	LABORATORY	1,122,373	1,815,691	2,938,064	-379,188	2,558,876	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	379,188	379,188	62.00
65.00	06500	RESPIRATORY THERAPY	555,892	201,817	757,709	-17,488	740,221	65.00
66.00	06600	PHYSICAL THERAPY	506,892	55,063	561,955	22,789	584,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,948	9,948	140,896	43,911	184,807	67.00
68.00	06800	SPEECH PATHOLOGY	88,084	6,712	94,796	-66,700	28,096	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,651	1,177,636	2,243,287	-112	2,243,175	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,227,004	3,227,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	770,247	770,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,686,817	1,686,817	73.00
74.00	07400	RENAL DIALYSIS	0	200,295	200,295	0	200,295	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	192,255	192,255	0	192,255	76.01
76.03	03951	WOUND CARE	36,613	14,688	51,301	0	51,301	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,471,055	1,981,825	3,452,880	192,175	3,645,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	79,855	112,320	192,175	-192,175	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,262,470	56,442,768	74,705,238	-339,774	74,365,464	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	5,891	-24,344	-18,453	0	-18,453	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	252	252	0	252	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	339,774	339,774	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	18,268,361	56,418,676	74,687,037	0	74,687,037	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	345,717	2,951,914	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-747,529	1,716,161	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,111	3,339,343	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,716,415	14,331,250	5.00
7.00	00700	OPERATION OF PLANT	-14,198	2,837,873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	220,833	8.00
9.00	00900	HOUSEKEEPING	0	1,156,060	9.00
10.00	01000	DIETARY	0	590,211	10.00
11.00	01100	CAFETERIA	-163,596	549,281	11.00
13.00	01300	NURSING ADMINISTRATION	110	1,453,615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	534,227	14.00
15.00	01500	PHARMACY	0	1,315,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,145	97,654	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,583,407	2,655,152	30.00
31.00	03100	INTENSIVE CARE UNIT	-818,120	1,349,193	31.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,570,961	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-2,335,479	92,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-66,991	1,819,026	54.00
54.01	05401	ULTRASOUND	0	220,258	54.01
56.00	05600	RADIOISOTOPE	0	343,080	56.00
57.00	05700	CT SCAN	0	448,925	57.00
58.00	05800	MRI	0	177,147	58.00
60.00	06000	LABORATORY	0	2,558,876	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	379,188	62.00
65.00	06500	RESPIRATORY THERAPY	0	740,221	65.00
66.00	06600	PHYSICAL THERAPY	0	584,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	184,807	67.00
68.00	06800	SPEECH PATHOLOGY	0	28,096	68.00
69.00	06900	ELECTROCARDIOLOGY	-106,940	2,136,235	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,227,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	770,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,686,817	73.00
74.00	07400	RENAL DIALYSIS	0	200,295	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	0	192,255	76.01
76.03	03951	WOUND CARE	0	51,301	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-1,411,067	2,233,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,621,171	58,744,293	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	-18,453	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	252	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	194.00
194.01	07953	MARKETING	0	339,774	194.01
194.02	07952	UNUSED SPACE	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,621,171	59,065,866	200.00

RECLASSIFICATIONS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet A-6
Date/Time Prepared:
9/29/2021 5:15 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,960,290		1.00
	0		0	2,960,290		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	34,704		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	34,704		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	150,704		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,079,648		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,531		3.00
	0		0	1,240,883		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	106,308	233,466		1.00
	0		106,308	233,466		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,192,300		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	770,247		2.00
	0		0	3,962,547		
	G - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,686,817		1.00
	0		0	1,686,817		
	I - PT, OT AND SP COST					
1.00	PHYSICAL THERAPY	66.00	25,273	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	37,242	6,669		2.00
	0		62,515	6,669		
	K - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	509,278	47,190		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	56,499	322,689		2.00
3.00	EMERGENCY	91.00	79,855	112,320		3.00
	0		645,632	482,199		
	M - PORTION OF DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	0	712,877		1.00
	0		0	712,877		
500.00	Grand Total: Increases		814,455	11,320,452		500.00

RECLASSIFICATIONS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet A-6
Date/Time Prepared:
9/29/2021 5:15 pm

	Decreases					Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other				
	6.00	7.00	8.00	9.00	10.00			
	A - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,960,290	0			1.00
	0		0	2,960,290				
	B - OXYGEN COSTS							
1.00	OPERATION OF PLANT	7.00	0	16,520	0			1.00
2.00	OPERATING ROOM	50.00	0	584	0			2.00
3.00	RESPIRATORY THERAPY	65.00	0	17,488	0			3.00
4.00	ELECTROCARDIOLOGY	69.00	0	112	0			4.00
	0		0	34,704				
	D - OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,240,883	12			1.00
2.00		0.00	0	0	13			2.00
3.00		0.00	0	0	12			3.00
	0		0	1,240,883				
	E - MARKETING DEPARTMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	106,308	233,466	0			1.00
	0		106,308	233,466				
	F - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,827,053	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	0	135,494	0			2.00
	0		0	3,962,547				
	G - DRUGS/IV SOLUTIONS							
1.00	PHARMACY	15.00	0	1,686,817	0			1.00
	0		0	1,686,817				
	I - PT, OT AND SP COST							
1.00	PHYSICAL THERAPY	66.00	0	2,484	0			1.00
2.00	SPEECH PATHOLOGY	68.00	62,515	4,185	0			2.00
	0		62,515	6,669				
	K - MISCELLANEOUS DEPARTMENTS							
1.00	RECOVERY ROOM	51.00	509,278	47,190	0			1.00
2.00	LABORATORY	60.00	56,499	322,689	0			2.00
3.00	AMBULANCE SERVICES	95.00	79,855	112,320	0			3.00
	0		645,632	482,199				
	M - PORTION OF DIETARY COST TO CAFETERIA							
1.00	DIETARY	10.00	0	712,877	0			1.00
	0		0	712,877				
500.00	Grand Total: Decreases		814,455	11,320,452				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,393,860	9,028	0	9,028	0	1.00
2.00	Land Improvements	822,554	0	0	0	0	2.00
3.00	Buildings and Fixtures	53,707,459	6,617	0	6,617	3,867	3.00
4.00	Building Improvements	23,083,477	1,599,955	0	1,599,955	513,621	4.00
5.00	Fixed Equipment	2,614,301	10,977	0	10,977	0	5.00
6.00	Movable Equipment	3,473,229	41,159	0	41,159	103,758	6.00
7.00	HIT designated Assets	6,491,022	45,930	0	45,930	390,220	7.00
8.00	Subtotal (sum of lines 1-7)	91,585,902	1,713,666	0	1,713,666	1,011,466	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	91,585,902	1,713,666	0	1,713,666	1,011,466	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,402,888	0				1.00
2.00	Land Improvements	822,554	0				2.00
3.00	Buildings and Fixtures	53,710,209	0				3.00
4.00	Building Improvements	24,169,811	0				4.00
5.00	Fixed Equipment	2,625,278	0				5.00
6.00	Movable Equipment	3,410,630	0				6.00
7.00	HIT designated Assets	6,146,732	0				7.00
8.00	Subtotal (sum of lines 1-7)	92,288,102	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	92,288,102	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,375,845	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,453,159	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,829,004	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,375,845				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,453,159				2.00
3.00	Total (sum of lines 1-2)	0	3,829,004				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part III
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	80,105,462	0	80,105,462	0.867993	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,182,640	0	12,182,640	0.132007	0	2.00
3.00	Total (sum of lines 1-2)	92,288,102	0	92,288,102	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,568,667	-8,312	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,647,736	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,216,403	-8,312	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	161,207	150,704	1,079,648	0	2,951,914	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	57,894	10,531	0	0	1,716,161	2.00
3.00	Total (sum of lines 1-2)	219,101	161,235	1,079,648	0	4,668,075	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-8,312	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-30,429	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	-6,293,222			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	-1,998,318			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-163,596	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,145	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	0	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	0	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	192,822	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-798,161	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-212	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/29/2021 5:15 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 INSERVICE EDUCATION	B	110	NURSING ADMINISTRATION	13.00	0	33.01
33.02 PATIENT PHONE SALARIES AND WAGES	A	-4,590	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 PATIENT PHONE BENEFIT EXPENSE	A	-1,111	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04 PATIENT PHONE DEPRECIATION EXPENSE	A	-6,890	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05 PATIENT TV DEPRECIATION EXPENSE	A	-372	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06 MARKETING EXPENSES	A	-162,300	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 EMPLOYEE GIFTS	A	-2,591	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 PHYSICIAN RECRUITING	A	-70,833	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 LOBBYING EXPENSE	A	-29,722	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 CHARITABLE CONTRIBUTIONS	A	-19,097	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 VOLUNTEERS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 ILLINOIS PROVIDER TAX	A	-6,096,097	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 CRNA COST	A	-28,782	ANESTHESIOLOGY	53.00	0	33.13
33.14 NON-ALLOWABLE LEGAL EXPENSES	A	-15,418	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 MISC NON-PATIENT REV	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16 SPECIAL EVENTS	A	-4,931	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17 PENALTIES	A	3,031	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18 LATE CHARGES	A	-65,807	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19 PATIENT TV CABLE EXPENSE	A	-14,198	OPERATION OF PLANT	7.00	0	33.19
33.20 TRAINING REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	33.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,621,171				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
9/29/2021 5:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - QHR COST	7,125	0 1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	1,645,355	0 2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	161,207	0 3.00
4.00		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	57,894	0 4.00
4.01		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	929,385	0 4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	239,541	1,258,247 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,780,578 4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				3,040,507	5,038,825 5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

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

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

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

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-1

Date/Time Prepared:
9/29/2021 5:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	7,125	0		1.00
2.00	1,645,355	0		2.00
3.00	161,207	11		3.00
4.00	57,894	11		4.00
4.01	929,385	0		4.01
4.02	-1,018,706	0		4.02
4.03	-3,780,578	0		4.03
5.00	-1,998,318			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOSPITAL CORPOR		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-2

Date/Time Prepared:
9/29/2021 5:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,583,407	1,583,407	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	818,120	818,120	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	2,306,697	2,306,697	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	66,991	66,991	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	106,940	106,940	0	0	0	5.00
6.00	91.00	EMERGENCY	1,411,067	1,411,067	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,293,222	6,293,222	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	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	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,583,407		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	818,120		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	2,306,697		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	66,991		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	106,940		5.00
6.00	91.00	EMERGENCY	0	0	0	1,411,067		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,293,222		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,951,914	2,951,914				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,716,161		1,716,161			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,339,343	16,319	9,487	3,365,149		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,331,250	322,116	187,269	447,740	15,288,375	5.00
7.00	00700	OPERATION OF PLANT	2,837,873	691,025	401,743	61,700	3,992,341	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	220,833	6,700	3,895	0	231,428	8.00
9.00	00900	HOUSEKEEPING	1,156,060	18,169	10,563	0	1,184,792	9.00
10.00	01000	DIETARY	590,211	49,509	28,783	0	668,503	10.00
11.00	01100	CAFETERIA	549,281	55,953	32,530	0	637,764	11.00
13.00	01300	NURSING ADMINISTRATION	1,453,615	77,135	44,844	210,020	1,785,614	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	534,227	31,489	18,307	43,798	627,821	14.00
15.00	01500	PHARMACY	1,315,872	27,841	16,186	180,132	1,540,031	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,654	46,335	26,938	8,134	179,061	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,655,152	368,707	214,356	452,384	3,690,599	30.00
31.00	03100	INTENSIVE CARE UNIT	1,349,193	165,401	96,159	196,753	1,807,506	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,570,961	277,321	161,227	499,851	6,509,360	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	92,183	3,836	2,230	0	98,249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,819,026	98,479	57,253	164,455	2,139,213	54.00
54.01	05401	ULTRASOUND	220,258	28,179	16,383	20,104	284,924	54.01
56.00	05600	RADIOISOTOPE	343,080	9,335	5,427	36,413	394,255	56.00
57.00	05700	CT SCAN	448,925	16,237	9,440	55,878	530,480	57.00
58.00	05800	MRI	177,147	17,251	10,029	19,430	223,857	58.00
60.00	06000	LABORATORY	2,558,876	64,004	37,210	199,658	2,859,748	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	379,188	3,404	1,979	10,583	395,154	62.00
65.00	06500	RESPIRATORY THERAPY	740,221	14,657	8,521	104,129	867,528	65.00
66.00	06600	PHYSICAL THERAPY	584,744	88,415	51,402	99,685	824,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,807	2,229	1,296	31,505	219,837	67.00
68.00	06800	SPEECH PATHOLOGY	28,096	1,256	730	4,790	34,872	68.00
69.00	06900	ELECTROCARDIOLOGY	2,136,235	56,602	32,907	199,617	2,425,361	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,227,004	0	0	0	3,227,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	770,247	0	0	0	770,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,686,817	0	0	0	1,686,817	73.00
74.00	07400	RENAL DIALYSIS	200,295	4,512	2,623	0	207,430	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	192,255	31,827	18,503	0	242,585	76.01
76.03	03951	WOUND CARE	51,301	38,014	22,100	6,858	118,273	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,233,988	128,846	74,908	290,515	2,728,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,744,293	2,761,103	1,605,228	3,344,132	58,421,532	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,132	5,309	0	14,441	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-18,453	178,315	103,668	1,103	264,633	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	252	3,364	1,956	0	5,572	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	339,774	0	0	19,914	359,688	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	59,065,866	2,951,914	1,716,161	3,365,149	59,065,866	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,288,375					5.00
7.00	00700	OPERATION OF PLANT	1,394,241	5,386,582				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,821	18,774	331,023			8.00
9.00	00900	HOUSEKEEPING	413,764	50,909	0	1,649,465		9.00
10.00	01000	DIETARY	233,461	138,722	0	43,036	1,083,722	10.00
11.00	01100	CAFETERIA	222,726	156,777	0	48,637	0	11.00
13.00	01300	NURSING ADMINISTRATION	623,588	216,126	0	67,049	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	219,253	88,230	0	27,372	0	14.00
15.00	01500	PHARMACY	537,823	78,010	0	24,201	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,533	129,827	0	40,276	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,288,864	1,033,091	67,009	320,497	763,988	30.00
31.00	03100	INTENSIVE CARE UNIT	631,234	463,442	40,875	143,774	114,157	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,273,266	777,033	43,220	241,059	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	34,311	10,750	0	3,335	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	747,075	275,930	32,834	85,602	0	54.00
54.01	05401	ULTRASOUND	99,504	78,956	0	24,495	0	54.01
56.00	05600	RADIOISOTOPE	137,685	26,155	0	8,114	0	56.00
57.00	05700	CT SCAN	185,259	45,496	0	14,114	0	57.00
58.00	05800	MRI	78,177	48,335	0	14,995	0	58.00
60.00	06000	LABORATORY	998,707	179,336	0	55,635	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	137,999	9,538	0	2,959	0	62.00
65.00	06500	RESPIRATORY THERAPY	302,966	41,068	0	12,740	0	65.00
66.00	06600	PHYSICAL THERAPY	287,851	247,732	18,762	76,854	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,773	6,245	0	1,937	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,178	3,520	0	1,092	0	68.00
69.00	06900	ELECTROCARDIOLOGY	847,006	158,594	24,793	49,201	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,126,963	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	268,993	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	589,085	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	72,441	12,642	0	3,922	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	84,718	89,176	1,340	27,665	0	76.01
76.03	03951	WOUND CARE	41,304	106,511	7,036	33,043	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	952,786	361,018	95,154	111,999	80,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,063,355	4,851,943	331,023	1,483,603	958,779	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,043	25,587	0	7,938	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,418	499,627	0	155,000	124,943	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,946	9,425	0	2,924	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	125,613	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	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)	15,288,375	5,386,582	331,023	1,649,465	1,083,722	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,065,904					11.00
13.00	01300	NURSING ADMINISTRATION	59,400	2,751,777				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,481	0	994,157			14.00
15.00	01500	PHARMACY	50,885	0	6,360	2,237,310		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,561	0	604	0	415,862	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	182,588	605,194	19,138	0	23,381	30.00
31.00	03100	INTENSIVE CARE UNIT	56,304	263,214	21,227	0	5,134	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	196,520	702,852	189,050	0	71,777	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	10,472	0	13,075	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,671	220,005	3,081	0	11,919	54.00
54.01	05401	ULTRASOUND	6,296	26,895	645	0	3,079	54.01
56.00	05600	RADIOISOTOPE	8,670	48,712	301	0	6,838	56.00
57.00	05700	CT SCAN	27,920	74,752	5,199	0	29,031	57.00
58.00	05800	MRI	5,058	25,994	48	0	5,298	58.00
60.00	06000	LABORATORY	111,060	0	96,356	0	77,176	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	1,797	62.00
65.00	06500	RESPIRATORY THERAPY	43,712	139,303	9,675	0	11,344	65.00
66.00	06600	PHYSICAL THERAPY	36,693	0	1,584	0	8,504	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,612	0	0	0	2,688	67.00
68.00	06800	SPEECH PATHOLOGY	1,755	0	0	0	409	68.00
69.00	06900	ELECTROCARDIOLOGY	75,812	267,045	27,063	0	35,000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	333,653	0	11,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	215,929	0	22,615	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,237,310	28,946	73.00
74.00	07400	RENAL DIALYSIS	0	0	640	0	1,349	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	759	0	858	76.01
76.03	03951	WOUND CARE	2,787	9,175	1,040	0	164	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	85,307	368,636	51,321	0	44,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,059,092	2,751,777	994,145	2,237,310	415,862	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	103	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	0	12	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	6,709	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	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)	1,065,904	2,751,777	994,157	2,237,310	415,862	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,994,349	0	7,994,349	30.00
31.00	03100	INTENSIVE CARE UNIT	3,546,867	0	3,546,867	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,004,137	0	11,004,137	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	170,192	0	170,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,577,330	0	3,577,330	54.00
54.01	05401	ULTRASOUND	524,794	0	524,794	54.01
56.00	05600	RADIOISOTOPE	630,730	0	630,730	56.00
57.00	05700	CT SCAN	912,251	0	912,251	57.00
58.00	05800	MRI	401,762	0	401,762	58.00
60.00	06000	LABORATORY	4,378,018	0	4,378,018	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	547,447	0	547,447	62.00
65.00	06500	RESPIRATORY THERAPY	1,428,336	0	1,428,336	65.00
66.00	06600	PHYSICAL THERAPY	1,502,226	0	1,502,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	319,092	0	319,092	67.00
68.00	06800	SPEECH PATHOLOGY	53,826	0	53,826	68.00
69.00	06900	ELECTROCARDIOLOGY	3,909,875	0	3,909,875	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,699,093	0	4,699,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,277,784	0	1,277,784	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,542,158	0	4,542,158	73.00
74.00	07400	RENAL DIALYSIS	298,424	0	298,424	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	447,101	0	447,101	76.01
76.03	03951	WOUND CARE	319,333	0	319,333	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,879,119	0	4,879,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,364,244	0	57,364,244	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,009	0	53,009	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,136,724	0	1,136,724	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	19,879	0	19,879	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	492,010	0	492,010	194.01
194.02	07952	UNUSED SPACE	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	59,065,866	0	59,065,866	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,319	9,487	25,806	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	322,116	187,269	509,385	5.00
7.00	00700	OPERATION OF PLANT	0	691,025	401,743	1,092,768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,700	3,895	10,595	8.00
9.00	00900	HOUSEKEEPING	0	18,169	10,563	28,732	9.00
10.00	01000	DIETARY	0	49,509	28,783	78,292	10.00
11.00	01100	CAFETERIA	0	55,953	32,530	88,483	11.00
13.00	01300	NURSING ADMINISTRATION	0	77,135	44,844	121,979	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,489	18,307	49,796	14.00
15.00	01500	PHARMACY	0	27,841	16,186	44,027	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,335	26,938	73,273	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	368,707	214,356	583,063	30.00
31.00	03100	INTENSIVE CARE UNIT	0	165,401	96,159	261,560	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	277,321	161,227	438,548	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,836	2,230	6,066	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,479	57,253	155,732	54.00
54.01	05401	ULTRASOUND	0	28,179	16,383	44,562	54.01
56.00	05600	RADIOISOTOPE	0	9,335	5,427	14,762	56.00
57.00	05700	CT SCAN	0	16,237	9,440	25,677	57.00
58.00	05800	MRI	0	17,251	10,029	27,280	58.00
60.00	06000	LABORATORY	0	64,004	37,210	101,214	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,404	1,979	5,383	62.00
65.00	06500	RESPIRATORY THERAPY	0	14,657	8,521	23,178	65.00
66.00	06600	PHYSICAL THERAPY	0	88,415	51,402	139,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,229	1,296	3,525	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,256	730	1,986	68.00
69.00	06900	ELECTROCARDIOLOGY	0	56,602	32,907	89,509	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,512	2,623	7,135	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	31,827	18,503	50,330	76.01
76.03	03951	WOUND CARE	0	38,014	22,100	60,114	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	128,846	74,908	203,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,761,103	1,605,228	4,366,331	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,132	5,309	14,441	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	178,315	103,668	281,983	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	3,364	1,956	5,320	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,951,914	1,716,161	4,668,075	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	512,817					5.00
7.00	00700	OPERATION OF PLANT	46,766	1,140,007				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,711	3,973	17,279			8.00
9.00	00900	HOUSEKEEPING	13,879	10,774	0	53,385		9.00
10.00	01000	DIETARY	7,831	29,359	0	1,393	116,875	10.00
11.00	01100	CAFETERIA	7,471	33,180	0	1,574	0	11.00
13.00	01300	NURSING ADMINISTRATION	20,917	45,741	0	2,170	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,354	18,673	0	886	0	14.00
15.00	01500	PHARMACY	18,040	16,510	0	783	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,098	27,476	0	1,304	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,232	218,642	3,498	10,372	82,393	30.00
31.00	03100	INTENSIVE CARE UNIT	21,173	98,082	2,134	4,653	12,311	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	76,258	164,450	2,256	7,802	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,151	2,275	0	108	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,059	58,397	1,714	2,771	0	54.00
54.01	05401	ULTRASOUND	3,338	16,710	0	793	0	54.01
56.00	05600	RADIOISOTOPE	4,618	5,535	0	263	0	56.00
57.00	05700	CT SCAN	6,214	9,629	0	457	0	57.00
58.00	05800	MRI	2,622	10,230	0	485	0	58.00
60.00	06000	LABORATORY	33,499	37,954	0	1,801	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,629	2,019	0	96	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,162	8,692	0	412	0	65.00
66.00	06600	PHYSICAL THERAPY	9,655	52,429	979	2,487	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,575	1,322	0	63	0	67.00
68.00	06800	SPEECH PATHOLOGY	408	745	0	35	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,411	33,564	1,294	1,592	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,801	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,023	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,759	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,430	2,676	0	127	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,842	18,873	70	895	0	76.01
76.03	03951	WOUND CARE	1,385	22,542	367	1,069	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	31,959	76,405	4,967	3,625	8,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	505,270	1,026,857	17,279	48,016	103,400	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	169	5,415	0	257	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,100	105,740	0	5,017	13,475	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	65	1,995	0	95	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	4,213	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	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)	512,817	1,140,007	17,279	53,385	116,875	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	130,708					11.00
13.00	01300	NURSING ADMINISTRATION	7,284	199,701				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,860	0	80,905			14.00
15.00	01500	PHARMACY	6,240	0	518	87,499		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	437	0	49	0	104,699	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,390	43,920	1,557	0	5,879	30.00
31.00	03100	INTENSIVE CARE UNIT	6,904	19,102	1,727	0	1,291	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,097	51,007	15,385	0	18,047	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	852	0	3,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,563	15,966	251	0	2,997	54.00
54.01	05401	ULTRASOUND	772	1,952	52	0	774	54.01
56.00	05600	RADIOISOTOPE	1,063	3,535	25	0	1,719	56.00
57.00	05700	CT SCAN	3,424	5,425	423	0	7,299	57.00
58.00	05800	MRI	620	1,886	4	0	1,332	58.00
60.00	06000	LABORATORY	13,619	0	7,841	0	19,543	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	452	62.00
65.00	06500	RESPIRATORY THERAPY	5,360	10,109	787	0	2,852	65.00
66.00	06600	PHYSICAL THERAPY	4,500	0	129	0	2,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,424	0	0	0	676	67.00
68.00	06800	SPEECH PATHOLOGY	215	0	0	0	103	68.00
69.00	06900	ELECTROCARDIOLOGY	9,297	19,380	2,202	0	8,800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	27,154	0	2,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,572	0	5,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	87,499	7,278	73.00
74.00	07400	RENAL DIALYSIS	0	0	52	0	339	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	62	0	216	76.01
76.03	03951	WOUND CARE	342	666	85	0	41	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10,461	26,753	4,177	0	11,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,872	199,701	80,904	87,499	104,699	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	13	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	0	1	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	823	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	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)	130,708	199,701	80,905	87,499	104,699	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,018,414	0	1,018,414	30.00
31.00	03100	INTENSIVE CARE UNIT	430,445	0	430,445	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	801,691	0	801,691	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,739	0	13,739	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,711	0	271,711	54.00
54.01	05401	ULTRASOUND	69,107	0	69,107	54.01
56.00	05600	RADIOISOTOPE	31,799	0	31,799	56.00
57.00	05700	CT SCAN	58,976	0	58,976	57.00
58.00	05800	MRI	44,608	0	44,608	58.00
60.00	06000	LABORATORY	217,002	0	217,002	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,660	0	12,660	62.00
65.00	06500	RESPIRATORY THERAPY	62,350	0	62,350	65.00
66.00	06600	PHYSICAL THERAPY	212,898	0	212,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,827	0	9,827	67.00
68.00	06800	SPEECH PATHOLOGY	3,529	0	3,529	68.00
69.00	06900	ELECTROCARDIOLOGY	195,579	0	195,579	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,840	0	67,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,281	0	32,281	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,536	0	114,536	73.00
74.00	07400	RENAL DIALYSIS	12,759	0	12,759	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	73,288	0	73,288	76.01
76.03	03951	WOUND CARE	86,664	0	86,664	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	384,089	0	384,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,225,792	0	4,225,792	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,282	0	20,282	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	409,336	0	409,336	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	7,476	0	7,476	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	194.00
194.01	07953	MARKETING	5,189	0	5,189	194.01
194.02	07952	UNUSED SPACE	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,668,075	0	4,668,075	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	218,519				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		218,519			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	17,964,770		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	2,390,253	-15,288,375	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	329,382	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	1,121,190	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	233,813	0	14.00
15.00	01500	PHARMACY	2,061	2,061	961,632	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	43,421	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,294	27,294	2,415,046	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,050,365	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,529	20,529	2,668,422	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	284	284	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	877,939	0	54.00
54.01	05401	ULTRASOUND	2,086	2,086	107,326	0	54.01
56.00	05600	RADIOISOTOPE	691	691	194,388	0	56.00
57.00	05700	CT SCAN	1,202	1,202	298,302	0	57.00
58.00	05800	MRI	1,277	1,277	103,729	0	58.00
60.00	06000	LABORATORY	4,738	4,738	1,065,874	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	56,499	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	555,892	0	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	532,165	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	168,190	0	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	25,569	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,065,651	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	2,814	36,613	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,538	9,538	1,550,910	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,394	204,394	17,852,571	-15,288,375	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	5,891	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	106,308	0	194.01
194.02	07952	UNUSED SPACE	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)	2,951,914	1,716,161	3,365,149	15,288,375	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.508729	7.853601	0.187319	0.349229	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,806	512,817	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001436	0.011714	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
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: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	142,312				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	258,858			8.00
9.00	00900	HOUSEKEEPING	1,345	0	140,471		9.00
10.00	01000	DIETARY	3,665	0	3,665	20,496	10.00
11.00	01100	CAFETERIA	4,142	0	4,142	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	14.00
15.00	01500	PHARMACY	2,061	0	2,061	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,294	52,401	27,294	14,449	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	31,964	12,244	2,159	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,529	33,798	20,529	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	284	0	284	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	25,676	7,290	0	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	57.00
58.00	05800	MRI	1,277	0	1,277	0	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	65.00
66.00	06600	PHYSICAL THERAPY	6,545	14,672	6,545	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	19,388	4,190	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	0	334	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	1,048	2,356	0	76.01
76.03	03951	WOUND CARE	2,814	5,502	2,814	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	9,538	74,409	9,538	1,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,187	258,858	126,346	18,133	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	0	13,200	2,363	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	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)	5,386,582	331,023	1,649,465	1,083,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.850512	1.278782	11.742388	52.874805	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,140,007	17,279	53,385	116,875	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.010618	0.066751	0.380043	5.702332	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	10,981,082				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,734,712			14.00
15.00	01500	PHARMACY	0	43,085	1,686,817		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,090	0	477,512,806	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,415,046	129,649	0	26,843,640	30.00
31.00	03100	INTENSIVE CARE UNIT	1,050,365	143,795	0	5,894,174	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,804,776	1,280,680	0	82,408,130	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	70,940	0	15,011,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	877,939	20,870	0	13,684,626	54.00
54.01	05401	ULTRASOUND	107,326	4,369	0	3,534,534	54.01
56.00	05600	RADIOISOTOPE	194,388	2,041	0	7,850,823	56.00
57.00	05700	CT SCAN	298,302	35,218	0	33,330,373	57.00
58.00	05800	MRI	103,729	324	0	6,082,179	58.00
60.00	06000	LABORATORY	0	652,742	0	88,670,466	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,063,116	62.00
65.00	06500	RESPIRATORY THERAPY	555,892	65,538	0	13,023,761	65.00
66.00	06600	PHYSICAL THERAPY	0	10,728	0	9,762,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,085,564	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	469,089	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,651	183,335	0	40,183,479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,260,267	0	13,171,747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,462,768	0	25,964,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,686,817	33,233,132	73.00
74.00	07400	RENAL DIALYSIS	0	4,338	0	1,548,795	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	5,139	0	984,537	76.01
76.03	03951	WOUND CARE	36,613	7,048	0	187,852	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	1,471,055	347,666	0	50,524,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,981,082	6,734,630	1,686,817	477,512,806	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	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	82	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	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)	2,751,777	994,157	2,237,310	415,862	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.250593	0.147617	1.326350	0.000871	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	199,701	80,905	87,499	104,699	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.018186	0.012013	0.051872	0.000219	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,994,349		7,994,349	0	7,994,349	30.00
31.00	03100	INTENSIVE CARE UNIT	3,546,867		3,546,867	0	3,546,867	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,004,137		11,004,137	0	11,004,137	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	170,192		170,192	0	170,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,577,330		3,577,330	0	3,577,330	54.00
54.01	05401	ULTRASOUND	524,794		524,794	0	524,794	54.01
56.00	05600	RADIOISOTOPE	630,730		630,730	0	630,730	56.00
57.00	05700	CT SCAN	912,251		912,251	0	912,251	57.00
58.00	05800	MRI	401,762		401,762	0	401,762	58.00
60.00	06000	LABORATORY	4,378,018		4,378,018	0	4,378,018	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	547,447		547,447	0	547,447	62.00
65.00	06500	RESPIRATORY THERAPY	1,428,336	0	1,428,336	0	1,428,336	65.00
66.00	06600	PHYSICAL THERAPY	1,502,226	0	1,502,226	0	1,502,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	319,092	0	319,092	0	319,092	67.00
68.00	06800	SPEECH PATHOLOGY	53,826	0	53,826	0	53,826	68.00
69.00	06900	ELECTROCARDIOLOGY	3,909,875		3,909,875	0	3,909,875	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,699,093		4,699,093	0	4,699,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,277,784		1,277,784	0	1,277,784	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,542,158		4,542,158	0	4,542,158	73.00
74.00	07400	RENAL DIALYSIS	298,424		298,424	0	298,424	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	447,101		447,101	0	447,101	76.01
76.03	03951	WOUND CARE	319,333		319,333	0	319,333	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,879,119		4,879,119	0	4,879,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,632,107		1,632,107	0	1,632,107	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	58,996,351	0	58,996,351	0	58,996,351	200.00
201.00		Less Observation Beds	1,632,107		1,632,107	0	1,632,107	201.00
202.00		Total (see instructions)	57,364,244	0	57,364,244	0	57,364,244	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,495,874		22,495,874			30.00
31.00	03100	INTENSIVE CARE UNIT	5,894,174		5,894,174			31.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,226,263	60,181,867	82,408,130	0.133532	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,698,695	10,312,321	15,011,016	0.011338	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,880	11,704,746	13,684,626	0.261412	0.000000	54.00
54.01	05401	ULTRASOUND	656,976	2,877,558	3,534,534	0.148476	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,414,955	5,435,868	7,850,823	0.080339	0.000000	56.00
57.00	05700	CT SCAN	7,090,119	26,240,254	33,330,373	0.027370	0.000000	57.00
58.00	05800	MRI	384,870	5,697,309	6,082,179	0.066056	0.000000	58.00
60.00	06000	LABORATORY	24,569,138	64,101,328	88,670,466	0.049374	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	667,894	1,395,222	2,063,116	0.265350	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	11,162,416	1,861,345	13,023,761	0.109672	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,670,782	5,092,136	9,762,918	0.153871	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,239,777	845,787	3,085,564	0.103414	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	320,715	148,374	469,089	0.114746	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	21,153,309	19,030,170	40,183,479	0.097301	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,656,685	6,515,062	13,171,747	0.356755	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,304,022	13,660,598	25,964,620	0.049213	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,177,683	16,055,449	33,233,132	0.136676	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,426,697	122,098	1,548,795	0.192681	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	984,537	984,537	0.454123	0.000000	76.01
76.03	03951	WOUND CARE	23,364	164,488	187,852	1.699918	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	10,431,718	40,092,517	50,524,235	0.096570	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,200,426	3,147,340	4,347,766	0.375390	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	181,846,432	295,666,374	477,512,806			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	181,846,432	295,666,374	477,512,806			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet C Part I Date/Time Prepared: 9/29/2021 5:15 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.133532		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.011338		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261412		54.00
54.01	05401	ULTRASOUND	0.148476		54.01
56.00	05600	RADIOISOTOPE	0.080339		56.00
57.00	05700	CT SCAN	0.027370		57.00
58.00	05800	MRI	0.066056		58.00
60.00	06000	LABORATORY	0.049374		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.265350		62.00
65.00	06500	RESPIRATORY THERAPY	0.109672		65.00
66.00	06600	PHYSICAL THERAPY	0.153871		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103414		67.00
68.00	06800	SPEECH PATHOLOGY	0.114746		68.00
69.00	06900	ELECTROCARDIOLOGY	0.097301		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.356755		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.049213		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136676		73.00
74.00	07400	RENAL DIALYSIS	0.192681		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.454123		76.01
76.03	03951	WOUND CARE	1.699918		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.096570		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.375390		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,994,349		7,994,349	0	7,994,349	30.00	
31.00	03100	INTENSIVE CARE UNIT	3,546,867		3,546,867	0	3,546,867	31.00	
43.00	04300	NURSERY	0		0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,004,137		11,004,137	0	11,004,137	50.00	
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	170,192		170,192	0	170,192	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,577,330		3,577,330	0	3,577,330	54.00	
54.01	05401	ULTRASOUND	524,794		524,794	0	524,794	54.01	
56.00	05600	RADIOISOTOPE	630,730		630,730	0	630,730	56.00	
57.00	05700	CT SCAN	912,251		912,251	0	912,251	57.00	
58.00	05800	MRI	401,762		401,762	0	401,762	58.00	
60.00	06000	LABORATORY	4,378,018		4,378,018	0	4,378,018	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	547,447		547,447	0	547,447	62.00	
65.00	06500	RESPIRATORY THERAPY	1,428,336	0	1,428,336	0	1,428,336	65.00	
66.00	06600	PHYSICAL THERAPY	1,502,226	0	1,502,226	0	1,502,226	66.00	
67.00	06700	OCCUPATIONAL THERAPY	319,092	0	319,092	0	319,092	67.00	
68.00	06800	SPEECH PATHOLOGY	53,826	0	53,826	0	53,826	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,909,875		3,909,875	0	3,909,875	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,699,093		4,699,093	0	4,699,093	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,277,784		1,277,784	0	1,277,784	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,542,158		4,542,158	0	4,542,158	73.00	
74.00	07400	RENAL DIALYSIS	298,424		298,424	0	298,424	74.00	
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00	
76.01	03610	SLEEP LAB	447,101		447,101	0	447,101	76.01	
76.03	03951	WOUND CARE	319,333		319,333	0	319,333	76.03	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	4,879,119		4,879,119	0	4,879,119	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,632,107		1,632,107	0	1,632,107	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00	
200.00		Subtotal (see instructions)	58,996,351	0	58,996,351	0	58,996,351	200.00	
201.00		Less Observation Beds	1,632,107		1,632,107	0	1,632,107	201.00	
202.00		Total (see instructions)	57,364,244	0	57,364,244	0	57,364,244	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

			Title XIX			Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,495,874		22,495,874			30.00	
31.00	03100	INTENSIVE CARE UNIT	5,894,174		5,894,174			31.00	
43.00	04300	NURSERY	0		0			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,226,263	60,181,867	82,408,130	0.133532	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	4,698,695	10,312,321	15,011,016	0.011338	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,979,880	11,704,746	13,684,626	0.261412	0.000000	54.00	
54.01	05401	ULTRASOUND	656,976	2,877,558	3,534,534	0.148476	0.000000	54.01	
56.00	05600	RADIOISOTOPE	2,414,955	5,435,868	7,850,823	0.080339	0.000000	56.00	
57.00	05700	CT SCAN	7,090,119	26,240,254	33,330,373	0.027370	0.000000	57.00	
58.00	05800	MRI	384,870	5,697,309	6,082,179	0.066056	0.000000	58.00	
60.00	06000	LABORATORY	24,569,138	64,101,328	88,670,466	0.049374	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	667,894	1,395,222	2,063,116	0.265350	0.000000	62.00	
65.00	06500	RESPIRATORY THERAPY	11,162,416	1,861,345	13,023,761	0.109672	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	4,670,782	5,092,136	9,762,918	0.153871	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,239,777	845,787	3,085,564	0.103414	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	320,715	148,374	469,089	0.114746	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	21,153,309	19,030,170	40,183,479	0.097301	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,656,685	6,515,062	13,171,747	0.356755	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,304,022	13,660,598	25,964,620	0.049213	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	17,177,683	16,055,449	33,233,132	0.136676	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	1,426,697	122,098	1,548,795	0.192681	0.000000	74.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.01	03610	SLEEP LAB	0	984,537	984,537	0.454123	0.000000	76.01	
76.03	03951	WOUND CARE	23,364	164,488	187,852	1.699918	0.000000	76.03	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	10,431,718	40,092,517	50,524,235	0.096570	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,200,426	3,147,340	4,347,766	0.375390	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00	
200.00		Subtotal (see instructions)	181,846,432	295,666,374	477,512,806			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	181,846,432	295,666,374	477,512,806			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet C Part I Date/Time Prepared: 9/29/2021 5:15 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,018,414	0	1,018,414	7,024	144.99	30.00
31.00	INTENSIVE CARE UNIT	430,445		430,445	1,187	362.63	31.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	1,448,859		1,448,859	8,211		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,675	387,848				30.00
31.00	INTENSIVE CARE UNIT	312	113,141				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	2,987	500,989				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges		Capital Costs (column 3 x column 4)
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	801,691	82,408,130	0.009728	10,618,320	103,295	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,739	15,011,016	0.000915	2,113,181	1,934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,711	13,684,626	0.019855	1,040,099	20,651	54.00
54.01	05401	ULTRASOUND	69,107	3,534,534	0.019552	338,139	6,611	54.01
56.00	05600	RADIOISOTOPE	31,799	7,850,823	0.004050	1,144,659	4,636	56.00
57.00	05700	CT SCAN	58,976	33,330,373	0.001769	3,678,871	6,508	57.00
58.00	05800	MRI	44,608	6,082,179	0.007334	196,354	1,440	58.00
60.00	06000	LABORATORY	217,002	88,670,466	0.002447	12,481,562	30,542	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,660	2,063,116	0.006136	434,007	2,663	62.00
65.00	06500	RESPIRATORY THERAPY	62,350	13,023,761	0.004787	5,236,015	25,065	65.00
66.00	06600	PHYSICAL THERAPY	212,898	9,762,918	0.021807	2,736,619	59,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,827	3,085,564	0.003185	1,311,737	4,178	67.00
68.00	06800	SPEECH PATHOLOGY	3,529	469,089	0.007523	221,141	1,664	68.00
69.00	06900	ELECTROCARDIOLOGY	195,579	40,183,479	0.004867	9,413,565	45,816	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,840	13,171,747	0.005150	3,425,541	17,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,281	25,964,620	0.001243	6,084,460	7,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,536	33,233,132	0.003446	7,934,970	27,344	73.00
74.00	07400	RENAL DIALYSIS	12,759	1,548,795	0.008238	868,876	7,158	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	73,288	984,537	0.074439	0	0	76.01
76.03	03951	WOUND CARE	86,664	187,852	0.461342	11,133	5,136	76.03
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	384,089	50,524,235	0.007602	5,617,149	42,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	207,917	4,347,766	0.047822	607,855	29,069	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	2,984,850	449,122,758		75,514,253	451,294	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0184		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part III Date/Time Prepared: 9/29/2021 5:15 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	7,024	0.00		2,675	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,187	0.00		312	31.00	
43.00	04300	NURSERY			0	0	0.00		0	43.00	
200.00		Total (lines 30 through 199)			0	8,211			2,987	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	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	82,408,130	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,011,016	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,684,626	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	3,534,534	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	7,850,823	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,330,373	0.000000	57.00
58.00	05800	MRI	0	0	0	6,082,179	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	88,670,466	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,063,116	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,023,761	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,762,918	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,085,564	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	469,089	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,183,479	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,171,747	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,964,620	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,233,132	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,548,795	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	984,537	0.000000	76.01
76.03	03951	WOUND CARE	0	0	0	187,852	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	50,524,235	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,347,766	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	449,122,758		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	10,618,320	0	19,409,045	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,113,181	0	3,161,915	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,040,099	0	3,461,288	0	54.00
54.01	05401	ULTRASOUND	0.000000	338,139	0	862,110	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	1,144,659	0	2,059,699	0	56.00
57.00	05700	CT SCAN	0.000000	3,678,871	0	8,133,918	0	57.00
58.00	05800	MRI	0.000000	196,354	0	1,845,087	0	58.00
60.00	06000	LABORATORY	0.000000	12,481,562	0	7,515,176	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	434,007	0	1,191,374	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,236,015	0	674,881	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,736,619	0	185,848	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,311,737	0	88,009	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	221,141	0	14,624	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,413,565	0	7,842,878	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,425,541	0	2,240,510	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,084,460	0	5,560,796	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,934,970	0	5,916,933	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	868,876	0	101,408	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	251,524	0	76.01
76.03	03951	WOUND CARE	0.000000	11,133	0	70,857	0	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.000000	5,617,149	0	10,036,112	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	607,855	0	1,130,359	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		75,514,253	0	81,754,351	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/29/2021 5:15 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.133532	19,409,045	6,810	0	2,591,729	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.011338	3,161,915	0	0	35,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261412	3,461,288	0	0	904,822	54.00
54.01	05401	ULTRASOUND	0.148476	862,110	0	0	128,003	54.01
56.00	05600	RADIOISOTOPE	0.080339	2,059,699	0	0	165,474	56.00
57.00	05700	CT SCAN	0.027370	8,133,918	0	0	222,625	57.00
58.00	05800	MRI	0.066056	1,845,087	0	0	121,879	58.00
60.00	06000	LABORATORY	0.049374	7,515,176	0	0	371,054	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.265350	1,191,374	0	0	316,131	62.00
65.00	06500	RESPIRATORY THERAPY	0.109672	674,881	0	0	74,016	65.00
66.00	06600	PHYSICAL THERAPY	0.153871	185,848	0	0	28,597	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103414	88,009	0	0	9,101	67.00
68.00	06800	SPEECH PATHOLOGY	0.114746	14,624	0	0	1,678	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097301	7,842,878	0	0	763,120	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.356755	2,240,510	0	0	799,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.049213	5,560,796	0	0	273,663	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136676	5,916,933	0	12,358	808,703	73.00
74.00	07400	RENAL DIALYSIS	0.192681	101,408	0	0	19,539	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.454123	251,524	0	0	114,223	76.01
76.03	03951	WOUND CARE	1.699918	70,857	0	0	120,451	76.03
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.096570	10,036,112	0	0	969,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.375390	1,130,359	0	0	424,325	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		81,754,351	6,810	12,358	9,263,483	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		81,754,351	6,810	12,358	9,263,483	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0184		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part V Date/Time Prepared: 9/29/2021 5:15 pm		
			Title XVIII		Hospital		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	909	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	ULTRASOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0					62.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,689					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
76.00	03020	ACUPUNCTURE	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.03	03951	WOUND CARE	0	0					76.03
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
200.00		Subtotal (see instructions)	909	1,689					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	909	1,689					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet D-1 Date/Time Prepared: 9/29/2021 5:15 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,024	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,024	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)			5,590	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			2,675	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)			7,994,349	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)			7,994,349	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)			7,994,349	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)			1,138.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,044,551	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,044,551	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		Title XVIII			Hospital	PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	3,546,867	1,187	2,988.09	312	932,284
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,336,308
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,313,143
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					500,989
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					451,294
52.00	Total Program excludable cost (sum of lines 50 and 51)					952,283
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,360,860
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					1,434
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,138.15
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,632,107

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/29/2021 5:15 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,018,414	7,994,349	0.127392	1,632,107	207,917	90.00
91.00 Nursing School cost	0	7,994,349	0.000000	1,632,107	0	91.00
92.00 Allied health cost	0	7,994,349	0.000000	1,632,107	0	92.00
93.00 All other Medical Education	0	7,994,349	0.000000	1,632,107	0	93.00

Health Financial Systems		HEARTLAND REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/29/2021 5:15 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		11,627,110	30.00
31.00	03100	INTENSIVE CARE UNIT		1,866,314	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.133532	10,618,320	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.011338	2,113,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261412	1,040,099	54.00
54.01	05401	ULTRASOUND	0.148476	338,139	54.01
56.00	05600	RADIOISOTOPE	0.080339	1,144,659	56.00
57.00	05700	CT SCAN	0.027370	3,678,871	57.00
58.00	05800	MRI	0.066056	196,354	58.00
60.00	06000	LABORATORY	0.049374	12,481,562	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.265350	434,007	62.00
65.00	06500	RESPIRATORY THERAPY	0.109672	5,236,015	65.00
66.00	06600	PHYSICAL THERAPY	0.153871	2,736,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103414	1,311,737	67.00
68.00	06800	SPEECH PATHOLOGY	0.114746	221,141	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097301	9,413,565	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.356755	3,425,541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.049213	6,084,460	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.136676	7,934,970	73.00
74.00	07400	RENAL DIALYSIS	0.192681	868,876	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.454123	0	76.01
76.03	03951	WOUND CARE	1.699918	11,133	76.03
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.096570	5,617,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.375390	607,855	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		75,514,253	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)		75,514,253	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part A Date/Time Prepared: 9/29/2021 5:15 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			5,863,361	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,795,734	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)			22,994	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			152,420	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)			90.07	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)			5.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)			13.71	31.00
32.00	Sum of lines 30 and 31			19.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)			5.12	33.00
34.00	Disproportionate share adjustment (see instructions)			110,837	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part A Date/Time Prepared: 9/29/2021 5:15 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	548,861	333,226		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	229,442	193,545		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	422,987			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	9,368,333			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		9,368,333		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		690,261		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		90,569		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,149,163		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,149,163		61.00
62.00	Deductibles billed to program beneficiaries		921,760		62.00
63.00	Coinsurance billed to program beneficiaries		16,211		63.00
64.00	Allowable bad debts (see instructions)		298,997		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		194,348		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		209,877		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,405,540		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		40,467		70.93
70.94	HRR adjustment amount (see instructions)		-32,651		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part A Date/Time Prepared: 9/29/2021 5:15 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,413,356	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		9,414,264	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-908	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		904,134	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
HVB Adjustment for HSP Bonus Payment				
101.00	HVB adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVB 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 9/29/2021 5:15 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,598	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,263,483	2.00
3.00	OPPS payments		5,581,650	3.00
4.00	Outlier payment (see instructions)		91,102	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)		2,598	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		19,168	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)		19,168	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)		19,168	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		16,570	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)		2,598	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		5,672,752	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		1,362	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,051,410	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,622,578	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)		4,622,578	30.00
31.00	Primary payer payments		714	31.00
32.00	Subtotal (line 30 minus line 31)		4,621,864	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)		213,931	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		139,055	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		173,873	36.00
37.00	Subtotal (see instructions)		4,760,919	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-52	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)		4,760,971	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		4,900,244	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)		-139,273	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part I
Date/Time Prepared:
9/29/2021 5:15 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,414,264		4,900,244	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,414,264		4,900,244	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		908		139,273	6.02	
7.00	Total Medicare program liability (see instructions)		9,413,356		4,760,971	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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part II
Date/Time Prepared:
9/29/2021 5:15 pm

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

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

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet G

Date/Time Prepared:
9/29/2021 5:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-726,783	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,581,680	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,266,567	0	0	0	6.00
7.00	Inventory	2,989,642	0	0	0	7.00
8.00	Prepaid expenses	927,956	0	0	0	8.00
9.00	Other current assets	719,427	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)	14,225,355	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,210,000	0	0	0	12.00
13.00	Land improvements	1,630,270	0	0	0	13.00
14.00	Accumulated depreciation	-135,856	0	0	0	14.00
15.00	Buildings	36,590,647	0	0	0	15.00
16.00	Accumulated depreciation	-1,015,782	0	0	0	16.00
17.00	Leasehold improvements	121,709	0	0	0	17.00
18.00	Accumulated depreciation	-47,418	0	0	0	18.00
19.00	Fixed equipment	597,487	0	0	0	19.00
20.00	Accumulated depreciation	-131,387	0	0	0	20.00
21.00	Automobiles and trucks	31,988	0	0	0	21.00
22.00	Accumulated depreciation	-3,920	0	0	0	22.00
23.00	Major movable equipment	5,815,406	0	0	0	23.00
24.00	Accumulated depreciation	-1,251,159	0	0	0	24.00
25.00	Minor equipment depreciable	1,263,846	0	0	0	25.00
26.00	Accumulated depreciation	-288,742	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)	47,387,089	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	14,974,885	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,974,885	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	76,587,329	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,225,789	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,128,622	0	0	0	38.00
39.00	Payroll taxes payable	713,110	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	35,296,733	0	0	0	43.00
44.00	Other current liabilities	7,314,892	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	49,679,146	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,679,146	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,908,183				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)	26,908,183	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	76,587,329	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-1

Date/Time Prepared:
9/29/2021 5:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		175,627,081		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		30,980,357				2.00
3.00	Total (sum of line 1 and line 2)		206,607,438		0		3.00
4.00	REORGANIZATION ADJUSTMENTS TO RE	-179,699,257		0		0	4.00
5.00	ROUNDING	2		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)		-179,699,255		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,908,183		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)		26,908,183		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	REORGANIZATION ADJUSTMENTS TO RE		0				4.00
5.00	ROUNDING		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: 14-0184

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
9/29/2021 5:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,495,874		22,495,874	1.00
2.00	SUBPROVIDER - IPF				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)	22,495,874		22,495,874	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,894,174		5,894,174	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,894,174		5,894,174	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,390,048		28,390,048	17.00
18.00	Ancillary services	141,824,240	252,426,517	394,250,757	18.00
19.00	Outpatient services	11,632,144	43,239,857	54,872,001	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	0	0	0	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)	181,846,432	295,666,374	477,512,806	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		74,687,037		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)		74,687,037		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0184

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-3

Date/Time Prepared:
9/29/2021 5:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	477,512,806	1.00
2.00	Less contractual allowances and discounts on patients' accounts	389,995,832	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,516,974	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,687,037	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,829,937	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	163,596	14.00
15.00	Revenue from rental of living quarters	8,312	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	2,145	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 INCOME	102	24.00
24.50	COVID-19 PHE Funding	18,004,855	24.50
25.00	Total other income (sum of lines 6-24)	18,179,010	25.00
26.00	Total (line 5 plus line 25)	31,008,947	26.00
27.00	GAIN LOSS DISP OF ASSETS	28,590	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	28,590	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	30,980,357	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0184	Period: From 05/01/2020 To 04/30/2021	Worksheet L Parts I-III Date/Time Prepared: 9/29/2021 5:15 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		658,405	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		31,856	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)		18.57	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)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		690,261	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