

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: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/24/2022 11:41 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/24/2022	Time: 11:41 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORWEGIAN AMERICAN HOSPITAL (14-0206) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	506,253	-23,240	0	0	1.00
2.00 Subprovider - IPF	0	3,054	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	509,307	-23,240	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		NORWEGIAN AMERICAN HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0206		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:41 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1044 N. FRANSISCO AVENUE		PO Box:						1.00	
2.00	City: CHICAGO		State: IL		Zip Code: 60622		County: COOK		2.00	
			Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
			8.00							
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		NORWEGIAN AMERICAN HOSPITAL	140206	16984	1	07/01/1966	N	P	0
4.00	Subprovider - IPF		NORWEGIAN AMERICAN HOSP - PSYCH	14S206	16984	4	10/01/2006	N	P	0
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2020	09/30/2021	20.00	
21.00	Type of Control (see instructions)						2		21.00	
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00	

Worksheet S-2
Part I
Date/Time Prepared:
2/24/2022 11:41 am

MCRIF32 - 17.2.173.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:41 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/24/2022 11:41 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:41 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:41 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	3,684,715	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0206		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:41 am	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
161.10	CORF		N	N	N		161.10
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N		161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N		161.30
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N		161.40
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	169.00
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/24/2022 11:41 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/14/2022	Y 01/14/2022
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/24/2022 11:41 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630 530-7100, X107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/24/2022 11:41 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	161	58,765	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)		161	58,765	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
8.01 NICU	31.01	0	0	0.00	0	8.01
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)		173	63,145	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		185				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: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,167	2,134	28,077			1.00
2.00 HMO and other (see instructions)	3,948	15,449				2.00
3.00 HMO IPF Subprovider	8	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)	6,167	2,134	28,077			7.00
8.00 INTENSIVE CARE UNIT	684	384	3,044			8.00
8.01 NICU	0	0	0			8.01
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		768	861			13.00
14.00 Total (see instructions)	6,851	3,286	31,982	20.00	654.46	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	891	776	3,347	0.00	9.38	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				20.00	663.84	27.00
28.00 Observation Bed Days		18	2,203			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	58	105			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: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	874	359	4,570	1.00
2.00 HMO and other (see instructions)			499	2,500		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
8.01 NICU						8.01
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	874	359	4,570	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	97	86	371	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/24/2022 11:41 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	50,276,553	0	50,276,553	1,380,789.00	36.41
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		277,229	0	277,229	1,084.00	255.75
4.01	Physicians - Part A - Teaching		584,969	0	584,969	5,061.00	115.58
5.00	Physician and Non Physician-Part B		2,305,414	0	2,305,414	23,317.00	98.87
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	133,000	980,799	1,113,799	41,943.00	26.56
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,698,858	0	1,698,858	49,992.00	33.98
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,751,964	0	3,751,964	42,496.00	88.29
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,829,384	0	8,829,384		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		349,447	0	349,447		
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		11,774	0	11,774		
22.01	Physician Part A - Teaching		42,587	0	42,587		
23.00	Physician Part B		189,405	0	189,405		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		287,744	0	287,744		
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: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/24/2022 11:41 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	397,289	0	397,289	12,689.00	31.31	26.00
27.00	Administrative & General	5.00	15,525,394	-980,799	14,544,595	262,401.00	55.43	27.00
28.00	Administrative & General under contract (see inst.)		115,944	0	115,944	2,800.00	41.41	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,616,057	0	1,616,057	66,151.00	24.43	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,357,700	0	1,357,700	83,792.00	16.20	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	750,847	-196,791	554,056	35,168.00	15.75	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	196,791	196,791	12,491.00	15.75	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	985,566	0	985,566	18,830.00	52.34	38.00
39.00	Central Services and Supply	14.00	535,228	0	535,228	18,465.00	28.99	39.00
40.00	Pharmacy	15.00	1,433,629	0	1,433,629	43,508.00	32.95	40.00
41.00	Medical Records & Medical Records Library	16.00	343,712	0	343,712	13,253.00	25.93	41.00
42.00	Social Service	17.00	551,199	0	551,199	20,922.00	26.35	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/24/2022 11:41 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	47,369,114	-980,799	46,388,315	1,313,268.00	35.32	1.00
2.00	Excluded area salaries (see instructions)	1,698,858	0	1,698,858	49,992.00	33.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	45,670,256	-980,799	44,689,457	1,263,276.00	35.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,751,964	0	3,751,964	42,496.00	88.29	4.00
5.00	Subtotal wage-related costs (see inst.)	8,841,158	0	8,841,158	0.00	19.78	5.00
6.00	Total (sum of lines 3 thru 5)	58,263,378	-980,799	57,282,579	1,305,772.00	43.87	6.00
7.00	Total overhead cost (see instructions)	23,612,565	-980,799	22,631,766	590,470.00	38.33	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
2/24/2022 11:41 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	558,565	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	4,051,359	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	160,362	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	65,591	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	253,679	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,042,163	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,781,699	17.00
18.00	Medicare Taxes - Employers Portion Only	706,485	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	90,439	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,710,342	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: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,751,964	9,710,342	1.00
2.00	Hospital	3,751,964	9,710,342	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet S-10

Date/Time Prepared:
2/24/2022 11:41 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.268151	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		74,454,285	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		180,260,202	6.00
7.00	Medicaid cost (line 1 times line 6)		48,336,953	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)	12,860,899	182,309	13,043,208
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,448,663	182,309	3,630,972
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	3,448,663	182,309	3,630,972
				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)		3,188,078	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		438,421	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		674,494	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,513,584	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		910,093	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,541,065	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,541,065	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/24/2022 11:41 am

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		393,970	393,970	2,778,875	3,172,845	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,019,877	2,019,877	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	397,289	6,443,214	6,840,503	-602	6,839,901	4.00
5.01	01160	COMMUNICATIONS	205,760	79,868	285,628	0	285,628	5.01
5.02	00550	DATA PROCESSING	1,543,599	2,661,070	4,204,669	-476,220	3,728,449	5.02
5.03	00570	ADMITTING	769,652	221,927	991,579	-4,832	986,747	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	68,508	2,222,103	2,290,611	-3,050	2,287,561	5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	12,937,875	20,765,116	33,702,991	-2,520,131	31,182,860	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,616,057	3,842,417	5,458,474	-1,123,973	4,334,501	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	496,832	496,832	8.00
9.00	00900	HOUSEKEEPING	1,357,700	907,161	2,264,861	-503,236	1,761,625	9.00
10.00	01000	DIETARY	750,847	1,868,784	2,619,631	-707,547	1,912,084	10.00
11.00	01100	CAFETERIA	0	0	0	686,583	686,583	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	985,566	147,097	1,132,663	-32,980	1,099,683	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	535,228	533,294	1,068,522	-43,641	1,024,881	14.00
15.00	01500	PHARMACY	1,433,629	1,869,900	3,303,529	-1,751,939	1,551,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343,712	749,372	1,093,084	-4,906	1,088,178	16.00
17.00	01700	SOCIAL SERVICE	551,199	161,395	712,594	-90	712,504	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	133,000	70,875	203,875	980,799	1,184,674	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,303,064	4,046,488	13,349,552	-444,993	12,904,559	30.00
31.00	03100	INTENSIVE CARE UNIT	1,856,396	1,295,764	3,152,160	-52,364	3,099,796	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	708,029	141,394	849,423	-20,778	828,645	40.00
43.00	04300	NURSERY	858,771	269,564	1,128,335	71,944	1,200,279	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,941,457	2,723,436	4,664,893	-1,268,040	3,396,853	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,746,317	788,759	2,535,076	-411,320	2,123,756	52.00
53.00	05300	ANESTHESIOLOGY	39,166	2,861,638	2,900,804	-22,692	2,878,112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,641,894	1,909,831	3,551,725	-253,333	3,298,392	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	3,143	5,748,454	5,751,597	-2,723	5,748,874	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	670,124	421,921	1,092,045	-14,307	1,077,738	65.00
66.00	06600	PHYSICAL THERAPY	338,583	108,865	447,448	-16,011	431,437	66.00
69.00	06900	ELECTROCARDIOLOGY	203,037	61,263	264,300	-26,252	238,048	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,471	23,279	72,750	-815	71,935	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	854,947	854,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,399,580	1,399,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,595,341	1,595,341	73.00
74.00	07400	RENAL DIALYSIS	0	910,177	910,177	-493	909,684	74.00
75.01	07501	CARDIAC CATH LAB	449,712	1,380,174	1,829,886	-932,618	897,268	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,102,942	1,377,502	4,480,444	-36,597	4,443,847	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	370,162	395,377	765,539	-1,839	763,700	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	316,640	201,125	517,765	-29,727	488,038	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	2,057,195	3,359,179	5,416,374	-95,737	5,320,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,285,724	70,961,753	120,247,477	80,992	120,328,469	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,304	2,304	0	2,304	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	830,025	230,373	1,060,398	-56,335	1,004,063	192.00
192.01	19201	PROHEALTH SERVICES	0	411,501	411,501	-9,675	401,826	192.01
192.02	19202	AUXILIARY	160,804	70,697	231,501	-14,982	216,519	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	50,276,553	71,676,628	121,953,181	0	121,953,181	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-54,686	3,118,159	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,019,877	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,839,901	4.00
5.01	01160	COMMUNICATIONS	0	285,628	5.01
5.02	00550	DATA PROCESSING	-12,500	3,715,949	5.02
5.03	00570	ADMITTING	0	986,747	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-45	2,287,516	5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	-11,998,817	19,184,043	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,334,501	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	496,832	8.00
9.00	00900	HOUSEKEEPING	0	1,761,625	9.00
10.00	01000	DIETARY	0	1,912,084	10.00
11.00	01100	CAFETERIA	-195,413	491,170	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,099,683	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-71,547	953,334	14.00
15.00	01500	PHARMACY	0	1,551,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-283	1,087,895	16.00
17.00	01700	SOCIAL SERVICE	0	712,504	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,184,674	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-321,083	12,583,476	30.00
31.00	03100	INTENSIVE CARE UNIT	-75,000	3,024,796	31.00
31.01	02060	NICU	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	828,645	40.00
43.00	04300	NURSERY	-158,287	1,041,992	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-278,425	3,118,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,123,756	52.00
53.00	05300	ANESTHESIOLOGY	-2,756,062	122,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-247,049	3,051,343	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	56.01
60.00	06000	LABORATORY	-41,966	5,706,908	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-5,726	1,072,012	65.00
66.00	06600	PHYSICAL THERAPY	0	431,437	66.00
69.00	06900	ELECTROCARDIOLOGY	-3,100	234,948	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	71,935	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	854,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,399,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,595,341	73.00
74.00	07400	RENAL DIALYSIS	0	909,684	74.00
75.01	07501	CARDIAC CATH LAB	-200,071	697,197	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,133,622	2,310,225	90.00
90.01	09001	PH CLINIC	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	-521,223	242,477	90.02
90.03	09003	DENTAL CLINIC	0	0	90.03
90.04	09004	WOUND CARE THERAPY	-89,230	398,808	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	90.05
91.00	09100	EMERGENCY	-1,510,404	3,810,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-20,674,539	99,653,930	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,304	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,004,063	192.00
192.01	19201	PROHEALTH SERVICES	0	401,826	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.02	19202	AUXILIARY	0	216,519	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-20,674,539	101,278,642	200.00

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/24/2022 11:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	95,079		1.00
	0		0	95,079		
	B - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,576,249		1.00
	0		0	1,576,249		
	C - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	854,947		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	1,399,580		2.00
	PATIENTS					
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	2,254,527		
	D - SHARED CAFETERIA EXP					
1.00	CAFETERIA	11.00	196,791	489,792		1.00
	0		196,791	489,792		
	F - DEPRECIATION CHARGED TO DEPTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,617,761		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
	0		0	3,617,761		
	G - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	642,284		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	443,628		2.00
	0		0	1,085,912		
	H - LAUNDRY EXP					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	496,832		1.00
	TOTALS		0	496,832		

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/24/2022 11:41 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	J - NURSERY EXP				1.00
	NURSERY	43.00	60,634	17,931	
	0		60,634	17,931	
1.00	K - CHARGEABLE DRUGS				1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	1,595,341	
	0		0	1,595,341	
1.00	L - INTERNS AND RESIDENTS				1.00
	I&R SERVICES-SALARY & FRINGES APPRV	21.00	980,799	0	
	TOTALS		980,799	0	
500.00	Grand Total: Increases		1,238,224	11,229,424	500.00

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	95,079	12		1.00
	0		0	95,079			
	B - EQUIP DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,576,249	9		1.00
	0		0	1,576,249			
	C - CHARGEABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	72,638	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	14,574	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	9,177	0		3.00
4.00	NURSERY	43.00	0	1,610	0		4.00
5.00	OPERATING ROOM	50.00	0	1,110,061	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12,443	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	9,630	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,781	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	285	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	8	0		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	54	0		11.00
12.00	RENAL DIALYSIS	74.00	0	493	0		12.00
13.00	CARDIAC CATH LAB	75.01	0	921,859	0		13.00
14.00	CLINIC	90.00	0	5,138	0		14.00
15.00	HEALTHWORKS CLINIC	90.02	0	1,151	0		15.00
16.00	WOUND CARE THERAPY	90.04	0	22,742	0		16.00
17.00	EMERGENCY	91.00	0	52,883	0		17.00
	0		0	2,254,527			
	D - SHARED CAFETERIA EXP						
1.00	DIETARY	10.00	196,791	489,792	0		1.00
	0		196,791	489,792			
	F - DEPRECIATION CHARGED TO DEPTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	602	9		1.00
2.00	DATA PROCESSING	5.02	0	476,220	0		2.00
3.00	ADMITTING	5.03	0	4,832	0		3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	3,050	0		4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	358,341	0		5.00
6.00	OPERATION OF PLANT	7.00	0	1,123,973	0		6.00
7.00	HOUSEKEEPING	9.00	0	6,404	0		7.00
8.00	DIETARY	10.00	0	20,964	0		8.00
9.00	NURSING ADMINISTRATION	13.00	0	32,980	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	43,641	0		10.00
11.00	PHARMACY	15.00	0	156,598	0		11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,906	0		12.00
13.00	SOCIAL SERVICE	17.00	0	90	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	293,790	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	37,790	0		15.00
16.00	SUBPROVIDER - IPF	40.00	0	11,601	0		16.00
17.00	NURSERY	43.00	0	5,011	0		17.00
18.00	OPERATING ROOM	50.00	0	157,979	0		18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	0	398,877	0		19.00
20.00	ANESTHESIOLOGY	53.00	0	13,062	0		20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	0	233,552	0		21.00
22.00	LABORATORY	60.00	0	2,723	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	14,022	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	16,011	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	26,244	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	761	0		26.00
27.00	CARDIAC CATH LAB	75.01	0	10,759	0		27.00
28.00	CLINIC	90.00	0	31,459	0		28.00
29.00	HEALTHWORKS CLINIC	90.02	0	688	0		29.00
30.00	WOUND CARE THERAPY	90.04	0	6,985	0		30.00
31.00	EMERGENCY	91.00	0	42,854	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	56,335	0		32.00
33.00	PROHEALTH SERVICES	192.01	0	9,675	0		33.00
34.00	AUXILIARY	192.02	0	14,982	0		34.00
	0		0	3,617,761			
	G - INTEREST EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	1,085,912	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,085,912			

RECLASSIFICATIONS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
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	Decreases						2/27/2022 11:41 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - LAUNDRY EXP						
1.00	HOUSEKEEPING	9.00	0	496,832	0		1.00
	TOTALS		0	496,832			
	J - NURSERY EXP						
1.00	ADULTS & PEDIATRICS	30.00	60,634	17,931	0		1.00
	0		60,634	17,931			
	K - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	1,595,341	0		1.00
	0		0	1,595,341			
	L - INTERNS AND RESIDENTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	980,799	0	0		1.00
	TOTALS		980,799	0			
500.00	Grand Total: Decreases		1,238,224	11,229,424			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

 Period:
 From 10/01/2020
 To 09/30/2021

 Worksheet A-7
 Part I
 Date/Time Prepared:
 2/24/2022 11:41 am

		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	4,840,913	0	0	0	0	1.00	
2.00	Land Improvements	3,692,771	28,166	0	28,166	0	2.00	
3.00	Buildings and Fixtures	54,116,666	4,061,072	0	4,061,072	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	30,862,586	3,482,829	0	3,482,829	0	5.00	
6.00	Movable Equipment	61,976,981	4,499,114	0	4,499,114	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	155,489,917	12,071,181	0	12,071,181	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	155,489,917	12,071,181	0	12,071,181	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	4,840,913	0				1.00	
2.00	Land Improvements	3,720,937	0				2.00	
3.00	Buildings and Fixtures	58,177,738	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	34,345,415	0				5.00	
6.00	Movable Equipment	66,476,095	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	167,561,098	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	167,561,098	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	393,970	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	393,970	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	393,970				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	393,970				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	96,244,090	0	96,244,090	0.591470	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	66,476,095	0	66,476,095	0.408530	0	2.00
3.00	Total (sum of lines 1-2)	162,720,185	0	162,720,185	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	2,435,482	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,576,249	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,011,731	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	587,598	95,079	0	0	3,118,159	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	443,628	0	0	0	2,019,877	2.00
3.00	Total (sum of lines 1-2)	1,031,226	95,079	0	0	5,138,036	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-54,686	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-71,510	OTHER ADMINISTRATIVE AND GENERAL	5.05	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	-11,101,009			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-195,413	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	-283	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	OTHER INCOME	B	-12,500	DATA PROCESSING	5.02	0	33.01
33.02	OTHER INCOME	B	-45	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.02
33.03	OTHER INCOME	B	-220,508	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.03
33.04	OTHER INCOME	B	-71,547	CENTRAL SERVICES & SUPPLY	14.00	0	33.04
33.05	OTHER INCOME	B	-2,930	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	OTHER INCOME	B	-358,906	CLINIC	90.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	NON ALLOW EXP	A	-18,117	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	NON ALLOW EXP	A	-5,429	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.11
33.12	CLINIC INTEGRATION EXP	A	-126	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.12
33.13	IL MEDICAID ASSESSEMENT	A	-8,553,390	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.13
33.14	LOBBYING PORTION OF DUES	A	-8,140	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
35.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02
35.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.03
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,674,539				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/24/2022 11:41 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	AGGREGATE-OTHER ADMINISTRATIVE AND G	3,121,597	3,121,597	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	321,083	321,083	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	75,000	75,000	0	0	0	3.00
4.00	43.00	AGGREGATE-NURSERY	158,287	158,287	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	278,425	278,425	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	2,756,062	2,756,062	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	244,119	244,119	0	0	0	7.00
8.00	60.00	AGGREGATE-LABORATORY	41,966	41,966	0	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	5,726	5,726	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	3,100	3,100	0	0	0	10.00
12.00	75.01	AGGREGATE-CARDIAC CATH LAB	200,071	200,071	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	1,884,940	1,606,005	278,935	211,500	1,084	13.00
14.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	521,223	521,223	0	0	0	14.00
15.00	90.04	AGGREGATE-WOUND CARE THERAPY	89,230	89,230	0	0	0	15.00
16.00	91.00	AGGREGATE-EMERGENCY	1,510,404	1,510,404	0	0	0	16.00
200.00			11,211,233	10,932,298	278,935		1,084	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
12.00	75.01	AGGREGATE-CARDIAC CATH LAB	0	0	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	110,224	5,511	0	0	0	13.00
14.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	0	0	0	0	0	14.00
15.00	90.04	AGGREGATE-WOUND CARE THERAPY	0	0	0	0	0	15.00
16.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	16.00
200.00			110,224	5,511	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.05	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	3,121,597		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	321,083		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	75,000		3.00
4.00	43.00	AGGREGATE-NURSERY	0	0	0	158,287		4.00
5.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	278,425		5.00
6.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	2,756,062		6.00
7.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	244,119		7.00
8.00	60.00	AGGREGATE-LABORATORY	0	0	0	41,966		8.00
9.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	5,726		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	3,100		10.00
12.00	75.01	AGGREGATE-CARDIAC CATH LAB	0	0	0	200,071		12.00
13.00	90.00	AGGREGATE-CLINIC	0	110,224	168,711	1,774,716		13.00
14.00	90.02	AGGREGATE-HEALTHWORKS CLINIC	0	0	0	521,223		14.00
15.00	90.04	AGGREGATE-WOUND CARE THERAPY	0	0	0	89,230		15.00
16.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,510,404		16.00
200.00			0	110,224	168,711	11,101,009		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,118,159	3,118,159			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,019,877		2,019,877		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,839,901	36,210	336	6,876,447	4.00
5.01	01160	COMMUNICATIONS	285,628	4,832	0	28,366	5.01
5.02	00550	DATA PROCESSING	3,715,949	76,234	265,885	212,804	5.02
5.03	00570	ADMITTING	986,747	72,109	2,698	106,106	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,287,516	17,266	1,703	9,445	5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	19,184,043	65,982	200,070	1,648,417	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,334,501	261,518	627,539	222,793	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496,832	44,148	0	0	8.00
9.00	00900	HOUSEKEEPING	1,761,625	42,253	3,576	187,175	9.00
10.00	01000	DIETARY	1,912,084	89,399	8,637	76,383	10.00
11.00	01100	CAFETERIA	491,170	40,503	3,068	27,130	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,099,683	28,932	18,413	135,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	953,334	132,660	24,366	73,788	14.00
15.00	01500	PHARMACY	1,551,590	57,985	87,432	197,643	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,087,895	59,687	2,739	47,385	16.00
17.00	01700	SOCIAL SERVICE	712,504	1,835	50	75,989	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,184,674	0	0	153,551	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,439	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,583,476	500,363	164,030	1,274,180	30.00
31.00	03100	INTENSIVE CARE UNIT	3,024,796	75,478	21,099	255,926	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	828,645	63,464	6,477	97,610	40.00
43.00	04300	NURSERY	1,041,992	46,474	2,798	126,751	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,118,428	219,229	88,203	267,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,123,756	38,345	222,702	240,751	52.00
53.00	05300	ANESTHESIOLOGY	122,050	8,009	7,293	5,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,051,343	117,240	130,397	226,355	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	5,706,908	97,900	1,520	433	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,072,012	29,364	7,829	92,385	65.00
66.00	06600	PHYSICAL THERAPY	431,437	31,091	8,939	46,678	66.00
69.00	06900	ELECTROCARDIOLOGY	234,948	38,093	14,653	27,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,935	5,216	425	6,820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	854,947	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,399,580	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,595,341	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	909,684	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	697,197	25,575	6,007	61,998	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,310,225	94,747	17,564	427,778	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	242,477	14,388	384	51,031	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	398,808	38,776	3,900	43,653	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	3,810,233	90,550	23,926	283,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,653,930	2,567,294	1,974,658	6,739,849	296,990

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,304	7,518	0	873	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,004,063	543,347	31,453	114,429	16,596 192.00
192.01	19201	PROHEALTH SERVICES	401,826	0	5,402	0	4,367 192.01
192.02	19202	AUXILIARY	216,519	0	8,364	22,169	0 192.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	101,278,642	3,118,159	2,019,877	6,876,447	318,826 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			DATA PROCESSING	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	4,275,239					5.02
5.03	00570	ADMITTING	349,792	1,521,819				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	505,256	0	2,846,517			5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	310,926	0	0	21,463,602	21,463,602	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	38,866	0	0	5,500,940	1,479,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	540,980	145,479	8.00
9.00	00900	HOUSEKEEPING	77,732	0	0	2,072,361	557,293	9.00
10.00	01000	DIETARY	77,732	0	0	2,173,843	584,583	10.00
11.00	01100	CAFETERIA	0	0	0	562,744	151,331	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,289,888	346,873	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	233,195	0	0	1,418,216	381,382	14.00
15.00	01500	PHARMACY	272,061	0	0	2,175,446	585,014	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,866	0	0	1,255,789	337,703	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	797,366	214,425	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,339,098	360,106	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,439	387	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	544,121	609,126	803,756	16,512,245	4,440,406	30.00
31.00	03100	INTENSIVE CARE UNIT	77,732	64,480	80,983	3,600,494	968,234	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	43,567	54,717	1,094,480	294,324	40.00
43.00	04300	NURSERY	77,732	18,798	23,609	1,340,774	360,557	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	155,463	49,036	164,723	4,083,699	1,098,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,732	16,844	26,294	2,748,171	739,030	52.00
53.00	05300	ANESTHESIOLOGY	0	9,831	24,294	179,497	48,270	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,597	78,172	240,393	3,977,967	1,069,743	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	699,581	202,715	473,941	7,203,962	1,937,268	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	77,732	35,817	49,117	1,368,623	368,046	65.00
66.00	06600	PHYSICAL THERAPY	77,732	6,953	25,862	631,312	169,771	66.00
69.00	06900	ELECTROCARDIOLOGY	77,732	17,536	40,580	458,521	123,304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77,732	926	1,239	164,293	44,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,208	21,491	888,646	238,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,836	32,141	1,447,557	389,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	206,738	310,562	2,112,641	568,125	73.00
74.00	07400	RENAL DIALYSIS	0	19,701	25,740	955,125	256,849	74.00
75.01	07501	CARDIAC CATH LAB	0	58,402	91,595	940,774	252,990	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	233,195	260	8,544	3,098,427	833,220	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	2,440	315,087	84,732	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	5,929	53,082	548,515	147,505	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	77,732	48,944	291,414	4,636,890	1,246,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,275,239	1,521,819	2,846,517	98,899,412	20,823,787	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,695	2,876	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,709,888	459,818	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	411,595	110,685	192.01

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			5.02	5.03	5.04	5A.04	5.05	
192.02	19202	AUXILIARY	0	0	0	247,052	66,436	192.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,275,239	1,521,819	2,846,517	101,278,642	21,463,602	202.00

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	6,980,236				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,258	805,717			8.00
9.00	00900	HOUSEKEEPING	0	114,140	0	2,743,794		9.00
10.00	01000	DIETARY	0	241,495	0	98,211	3,098,132	10.00
11.00	01100	CAFETERIA	0	109,411	0	44,495	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	78,156	0	31,784	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	358,356	0	145,736	0	14.00
15.00	01500	PHARMACY	0	156,635	0	63,700	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	161,234	0	65,571	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,956	0	2,015	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,887	0	1,581	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,351,641	257,764	549,683	2,525,426	30.00
31.00	03100	INTENSIVE CARE UNIT	0	203,891	34,366	82,918	272,777	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	171,437	0	69,720	299,929	40.00
43.00	04300	NURSERY	0	125,541	43,020	51,055	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	592,207	145,913	240,838	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	103,581	122,765	42,124	0	52.00
53.00	05300	ANESTHESIOLOGY	0	21,636	0	8,799	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	316,703	58,003	128,796	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	264,459	0	107,550	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	79,322	0	32,258	0	65.00
66.00	06600	PHYSICAL THERAPY	0	83,986	14,908	34,155	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	102,901	0	41,848	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,089	0	5,730	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	0	69,087	0	28,096	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	255,941	30,916	104,086	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	38,867	1,285	15,806	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	104,747	4,298	42,598	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	244,605	92,479	99,475	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,492,169	805,717	2,138,628	3,098,132	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,308	0	8,259	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,467,759	0	596,907	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,980,236	805,717	2,743,794	3,098,132	202.00

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	867,981					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	17,316	0	1,764,017			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,990	0	0	2,320,680		14.00
15.00	01500	PHARMACY	40,027	0	0	0	3,020,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,188	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	19,248	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	38,573	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	285,335	0	930,456	184	317,042	30.00
31.00	03100	INTENSIVE CARE UNIT	44,676	0	145,686	0	288,337	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	17,947	0	58,524	0	36,960	40.00
43.00	04300	NURSERY	12,934	0	42,177	0	6,744	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,397	0	164,341	4,186	154,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,986	0	107,564	0	84,015	52.00
53.00	05300	ANESTHESIOLOGY	2,124	0	6,926	0	6,428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,245	0	0	0	2,473	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	3,233	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	21,161	0	69,006	0	1,534	65.00
66.00	06600	PHYSICAL THERAPY	7,730	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,434	0	17,719	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,875	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	878,239	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,437,710	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,747,160	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	16,874	74.00
75.01	07501	CARDIAC CATH LAB	7,787	0	25,394	0	10,005	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	78,695	0	0	0	99,383	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	10,485	0	0	0	15,919	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	9,605	0	0	0	22,448	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	60,174	0	196,224	11	197,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	839,932	0	1,764,017	2,320,330	3,011,187	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,554	0	0	175	9,476	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
192.02	19202	AUXILIARY	8,495	0	0	175	159	192.02
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)	867,981	0	1,764,017	2,320,680	3,020,822	202.00

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,832,485					16.00
17.00	01700	SOCIAL SERVICE	0	1,038,010				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,737,777	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	517,460	903,069	0	0	1,563,999	30.00
31.00	03100	INTENSIVE CARE UNIT	52,133	41,520	0	0	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	35,224	0	0	0	0	40.00
43.00	04300	NURSERY	15,198	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	106,040	31,140	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,927	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,639	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,753	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	305,099	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	31,619	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	16,648	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	26,124	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	798	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,835	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,691	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	199,924	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,570	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	58,964	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,500	0	0	0	173,778	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,570	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	34,172	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	187,597	62,281	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,832,485	1,038,010	0	0	1,737,777	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS	SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,832,485	1,038,010	0	0	1,737,777	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
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Cost Center Description			INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,294					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,565	0	30,161,275	-1,570,564	28,590,711	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,735,032	0	5,735,032	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	2,078,545	0	2,078,545	40.00
43.00	04300	NURSERY	0	0	1,998,000	0	1,998,000	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	6,671,613	0	6,671,613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,997,163	0	3,997,163	52.00
53.00	05300	ANESTHESIOLOGY	0	0	289,319	0	289,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,754,683	0	5,754,683	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	9,821,571	0	9,821,571	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,971,569	0	1,971,569	65.00
66.00	06600	PHYSICAL THERAPY	0	0	958,510	0	958,510	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	775,851	0	775,851	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	230,966	0	230,966	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,019,692	0	2,019,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,295,231	0	3,295,231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,627,850	0	4,627,850	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,245,418	0	1,245,418	74.00
75.01	07501	CARDIAC CATH LAB	0	0	1,393,097	0	1,393,097	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	729	0	4,680,675	-174,507	4,506,168	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	483,751	0	483,751	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	913,888	0	913,888	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	7,024,631	0	7,024,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,294	0	96,128,330	-1,745,071	94,383,259	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
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Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER					
			PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	42,138	0	42,138	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,263,577	0	4,263,577	192.00
192.01	19201	PROHEALTH SERVICES	0	0	522,280	0	522,280	192.01
192.02	19202	AUXILIARY	0	0	322,317	0	322,317	192.02
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)	7,294	0	101,278,642	-1,745,071	99,533,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	36,210	336	36,546	4.00
5.01	01160	COMMUNICATIONS	0	4,832	0	4,832	5.01
5.02	00550	DATA PROCESSING	0	76,234	265,885	342,119	5.02
5.03	00570	ADMITTING	0	72,109	2,698	74,807	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	17,266	1,703	18,969	5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	0	65,982	200,070	266,052	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	261,518	627,539	889,057	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,148	0	44,148	8.00
9.00	00900	HOUSEKEEPING	0	42,253	3,576	45,829	9.00
10.00	01000	DIETARY	0	89,399	8,637	98,036	10.00
11.00	01100	CAFETERIA	0	40,503	3,068	43,571	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	28,932	18,413	47,345	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	132,660	24,366	157,026	14.00
15.00	01500	PHARMACY	0	57,985	87,432	145,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,687	2,739	62,426	16.00
17.00	01700	SOCIAL SERVICE	0	1,835	50	1,885	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,439	0	1,439	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	500,363	164,030	664,393	30.00
31.00	03100	INTENSIVE CARE UNIT	0	75,478	21,099	96,577	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	63,464	6,477	69,941	40.00
43.00	04300	NURSERY	0	46,474	2,798	49,272	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	219,229	88,203	307,432	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38,345	222,702	261,047	52.00
53.00	05300	ANESTHESIOLOGY	0	8,009	7,293	15,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,240	130,397	247,637	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	0	97,900	1,520	99,420	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	29,364	7,829	37,193	65.00
66.00	06600	PHYSICAL THERAPY	0	31,091	8,939	40,030	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,093	14,653	52,746	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,216	425	5,641	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	0	25,575	6,007	31,582	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	94,747	17,564	112,311	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	14,388	384	14,772	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	38,776	3,900	42,676	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	90,550	23,926	114,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,567,294	1,974,658	4,541,952	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,518	0	7,518	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	543,347	31,453	574,800	608 192.00
192.01	19201	PROHEALTH SERVICES	0	0	5,402	5,402	0 192.01
192.02	19202	AUXILIARY	0	0	8,364	8,364	118 192.02
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,118,159	2,019,877	5,138,036	36,546 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
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Cost Center Description			COMMUNICATIONS	DATA PROCESSING	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
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
5.01	01160	COMMUNICATIONS	4,983					5.01
5.02	00550	DATA PROCESSING	68	343,318				5.02
5.03	00570	ADMITTING	68	28,090	103,529			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	396	40,574	0	59,989		5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	846	24,969	0	0	300,618	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	246	3,121	0	0	20,717	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	2,037	8.00
9.00	00900	HOUSEKEEPING	0	6,242	0	0	7,805	9.00
10.00	01000	DIETARY	150	6,242	0	0	8,187	10.00
11.00	01100	CAFETERIA	14	0	0	0	2,119	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	109	0	0	0	4,858	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14	18,726	0	0	5,341	14.00
15.00	01500	PHARMACY	137	21,848	0	0	8,193	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	300	3,121	0	0	4,729	16.00
17.00	01700	SOCIAL SERVICE	109	0	0	0	3,003	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	14	0	0	0	5,043	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	5	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	519	43,695	41,444	17,047	62,219	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,242	4,386	1,702	13,559	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	2,964	1,150	4,122	40.00
43.00	04300	NURSERY	41	6,242	1,279	496	5,049	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	328	12,484	3,336	3,463	15,379	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27	6,242	1,146	553	10,350	52.00
53.00	05300	ANESTHESIOLOGY	41	0	669	511	676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	273	9,363	5,318	5,053	14,981	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	328	56,181	13,789	9,963	27,130	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	68	6,242	2,436	1,033	5,154	65.00
66.00	06600	PHYSICAL THERAPY	41	6,242	473	544	2,378	66.00
69.00	06900	ELECTROCARDIOLOGY	109	6,242	1,193	853	1,727	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,242	63	26	619	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	830	452	3,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,077	676	5,451	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,063	6,528	7,956	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,340	541	3,597	74.00
75.01	07501	CARDIAC CATH LAB	0	0	3,973	1,925	3,543	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	96	18,726	18	180	11,669	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	68	0	0	51	1,187	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	68	0	403	1,116	2,066	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	164	6,242	3,329	6,126	17,463	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,642	343,318	103,529	59,989	291,659	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14	0	0	0	40	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	259	0	0	0	6,439	192.00
192.01	19201	PROHEALTH SERVICES	68	0	0	0	1,550	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
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Cost Center Description			COMMUNICATIONS	DATA PROCESSING	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
192.02	19202	AUXILIARY	0	0	0	0	930	192.02
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)	4,983	343,318	103,529	59,989	300,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
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To 09/30/2021Worksheet B
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	914,326				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,621	61,806			8.00
9.00	00900	HOUSEKEEPING	0	14,951	0	75,822		9.00
10.00	01000	DIETARY	0	31,633	0	2,714	147,368	10.00
11.00	01100	CAFETERIA	0	14,332	0	1,230	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	10,237	0	878	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	46,940	0	4,027	0	14.00
15.00	01500	PHARMACY	0	20,517	0	1,760	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,120	0	1,812	0	16.00
17.00	01700	SOCIAL SERVICE	0	649	0	56	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	509	0	44	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	177,049	19,772	15,190	120,126	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,707	2,636	2,291	12,975	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	22,456	0	1,927	14,267	40.00
43.00	04300	NURSERY	0	16,444	3,300	1,411	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	77,572	11,193	6,655	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,568	9,417	1,164	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,834	0	243	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,484	4,449	3,559	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	34,641	0	2,972	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,390	0	891	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,001	1,144	944	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,479	0	1,156	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,846	0	158	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	0	9,049	0	776	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	33,525	2,372	2,876	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	5,091	99	437	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	13,721	330	1,177	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	32,040	7,094	2,749	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	719,406	61,806	59,097	147,368	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,660	0	228	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192,260	0	16,497	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	914,326	61,806	75,822	147,368	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	61,410					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,225	0	65,374			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,202	0	0	233,668		14.00
15.00	01500	PHARMACY	2,832	0	0	0	201,755	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	862	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,362	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,729	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,187	0	34,483	19	21,175	30.00
31.00	03100	INTENSIVE CARE UNIT	3,161	0	5,399	0	19,257	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	1,270	0	2,169	0	2,468	40.00
43.00	04300	NURSERY	915	0	1,563	0	450	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,566	0	6,090	421	10,331	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,334	0	3,986	0	5,611	52.00
53.00	05300	ANESTHESIOLOGY	150	0	257	0	429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,272	0	0	0	165	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	216	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,497	0	2,557	0	102	65.00
66.00	06600	PHYSICAL THERAPY	547	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	384	0	657	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	133	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	88,430	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,761	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	116,691	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,127	74.00
75.01	07501	CARDIAC CATH LAB	551	0	941	0	668	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,568	0	0	0	6,638	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	742	0	0	0	1,063	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	680	0	0	0	1,499	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	4,257	0	7,272	1	13,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,426	0	65,374	233,632	201,111	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,383	0	0	18	633	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
192.02	19202	AUXILIARY	601	0	0	18	11	192.02
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)	61,410	0	65,374	233,668	201,755	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,622					16.00
17.00	01700	SOCIAL SERVICE	0	7,468				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			8,602	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,674	6,497				30.00
31.00	03100	INTENSIVE CARE UNIT	2,694	299				31.00
31.01	02060	NICU	0	0				31.01
40.00	04000	SUBPROVIDER - IPF	1,820	0				40.00
43.00	04300	NURSERY	785	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,479	224				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	875	0				52.00
53.00	05300	ANESTHESIOLOGY	808	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,996	0				54.00
56.01	05601	NUCLEAR MEDICINE	0	0				56.01
60.00	06000	LABORATORY	15,765	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	1,634	0				65.00
66.00	06600	PHYSICAL THERAPY	860	0				66.00
69.00	06900	ELECTROCARDIOLOGY	1,350	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	715	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,069	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,330	0				73.00
74.00	07400	RENAL DIALYSIS	856	0				74.00
75.01	07501	CARDIAC CATH LAB	3,047	0				75.01
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	284	0				90.00
90.01	09001	PH CLINIC	0	0				90.01
90.02	09002	HEALTHWORKS CLINIC	81	0				90.02
90.03	09003	DENTAL CLINIC	0	0				90.03
90.04	09004	WOUND CARE THERAPY	1,766	0				90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0				90.05
91.00	09100	EMERGENCY	9,693	448				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0				93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,622	7,468	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0				190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
192.01	19201	PROHEALTH SERVICES	0	0				192.01
192.02	19202	AUXILIARY	0	0				192.02
200.00		Cross Foot Adjustments			0	0	8,602	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,622	7,468	0	0	8,602	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,997					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			1,277,264	0	1,277,264	30.00
31.00	03100	INTENSIVE CARE UNIT			199,246	0	199,246	31.00
31.01	02060	NICU			0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF			125,073	0	125,073	40.00
43.00	04300	NURSERY			87,921	0	87,921	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			465,376	0	465,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			317,600	0	317,600	52.00
53.00	05300	ANESTHESIOLOGY			21,949	0	21,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			344,754	0	344,754	54.00
56.01	05601	NUCLEAR MEDICINE			0	0	0	56.01
60.00	06000	LABORATORY			260,407	0	260,407	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			69,688	0	69,688	65.00
66.00	06600	PHYSICAL THERAPY			64,452	0	64,452	66.00
69.00	06900	ELECTROCARDIOLOGY			80,045	0	80,045	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			14,805	0	14,805	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			93,774	0	93,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			153,034	0	153,034	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			155,568	0	155,568	73.00
74.00	07400	RENAL DIALYSIS			7,461	0	7,461	74.00
75.01	07501	CARDIAC CATH LAB			56,385	0	56,385	75.01
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC			196,537	0	196,537	90.00
90.01	09001	PH CLINIC			0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC			23,862	0	23,862	90.02
90.03	09003	DENTAL CLINIC			0	0	0	90.03
90.04	09004	WOUND CARE THERAPY			65,734	0	65,734	90.04
90.05	09005	FAMILY PRACTICE CLINIC			0	0	0	90.05
91.00	09100	EMERGENCY			226,083	0	226,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM			0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF			0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4,307,018	0	4,307,018	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-OTHER					
			PRGM COSTS APPRV					
			22.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			10,460	0	10,460	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			792,897	0	792,897	192.00
192.01	19201	PROHEALTH SERVICES			7,020	0	7,020	192.01
192.02	19202	AUXILIARY			10,042	0	10,042	192.02
200.00		Cross Foot Adjustments	1,997	0	10,599	0	10,599	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,997	0	5,138,036	0	5,138,036	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
		BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP ((DOLLAR VALUE))				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	260,059				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,617,760			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,020	602	49,879,264		4.00
5.01	01160	COMMUNICATIONS	403	0	205,760	365	5.01
5.02	00550	DATA PROCESSING	6,358	476,220	1,543,599	5	110 5.02
5.03	00570	ADMITTING	6,014	4,832	769,652	5	9 5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,440	3,050	68,508	29	13 5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	5,503	358,341	11,957,076	62	8 5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	21,811	1,123,973	1,616,057	18	1 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,682	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	3,524	6,404	1,357,700	0	2 9.00
10.00	01000	DIETARY	7,456	15,469	554,056	11	2 10.00
11.00	01100	CAFETERIA	3,378	5,495	196,791	1	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	2,413	32,980	985,566	8	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,064	43,641	535,228	1	6 14.00
15.00	01500	PHARMACY	4,836	156,598	1,433,629	10	7 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,978	4,906	343,712	22	1 16.00
17.00	01700	SOCIAL SERVICE	153	90	551,199	8	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,113,799	1	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	120	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,731	293,790	9,242,430	38	14 30.00
31.00	03100	INTENSIVE CARE UNIT	6,295	37,790	1,856,396	0	2 31.00
31.01	02060	NICU	0	0	0	0	0 31.01
40.00	04000	SUBPROVIDER - IPF	5,293	11,601	708,029	0	0 40.00
43.00	04300	NURSERY	3,876	5,011	919,405	3	2 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,284	157,979	1,941,457	24	4 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,198	398,877	1,746,317	2	2 52.00
53.00	05300	ANESTHESIOLOGY	668	13,062	39,166	3	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,778	233,552	1,641,894	20	3 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0 56.01
60.00	06000	LABORATORY	8,165	2,723	3,143	24	18 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	2,449	14,022	670,124	5	2 65.00
66.00	06600	PHYSICAL THERAPY	2,593	16,011	338,583	3	2 66.00
69.00	06900	ELECTROCARDIOLOGY	3,177	26,244	203,037	8	2 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	761	49,471	0	2 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.01	07501	CARDIAC CATH LAB	2,133	10,759	449,712	0	0 75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,902	31,459	3,102,942	7	6 90.00
90.01	09001	PH CLINIC	0	0	0	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	1,200	688	370,162	5	0 90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0 90.03
90.04	09004	WOUND CARE THERAPY	3,234	6,985	316,640	5	0 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	7,552	42,854	2,057,195	12	2 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,116	3,536,769	48,888,435	340	110 118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
			BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP ((DOLLAR VALUE))				
			1.00	2.00	4.00	5.01	5.02	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	0	0	1	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,316	56,335	830,025	19	0	192.00
192.01	19201	PROHEALTH SERVICES	0	9,675	0	5	0	192.01
192.02	19202	AUXILIARY	0	14,981	160,804	0	0	192.02
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)	3,118,159	2,019,877	6,876,447	318,826	4,275,239	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.990198	0.558323	0.137862	873.495890	38,865.809091	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			36,546	4,983	343,318	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000733	13.652055	3,121.072727	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: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			ADMITTING (INPATIENT CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS ((SQUARE FEET))	
			5.03	5.04	5A.05	5.05	6.00	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING	236,334,105					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	351,977,512				5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	0	0	-21,463,602	79,815,040		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	5,500,940	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	540,980	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,072,361	0	9.00
10.00	01000	DIETARY	0	0	0	2,173,843	0	10.00
11.00	01100	CAFETERIA	0	0	0	562,744	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,289,888	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,418,216	0	14.00
15.00	01500	PHARMACY	0	0	0	2,175,446	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,255,789	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	797,366	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,339,098	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,439	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,589,536	99,379,270	0	16,512,245	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,013,989	10,013,989	0	3,600,494	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	6,766,058	6,766,058	0	1,094,480	0	40.00
43.00	04300	NURSERY	2,919,374	2,919,374	0	1,340,774	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,615,468	20,368,874	0	4,083,699	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,615,908	3,251,442	0	2,748,171	0	52.00
53.00	05300	ANESTHESIOLOGY	1,526,858	3,004,098	0	179,497	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,140,455	29,725,912	0	3,977,967	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	31,482,396	58,605,304	0	7,203,962	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,562,472	6,073,543	0	1,368,623	0	65.00
66.00	06600	PHYSICAL THERAPY	1,079,867	3,197,914	0	631,312	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,723,396	5,017,969	0	458,521	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	143,775	153,225	0	164,293	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,895,984	2,657,452	0	888,646	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,459,400	3,974,450	0	1,447,557	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,107,107	38,402,565	0	2,112,641	0	73.00
74.00	07400	RENAL DIALYSIS	3,059,636	3,182,932	0	955,125	0	74.00
75.01	07501	CARDIAC CATH LAB	9,069,975	11,326,153	0	940,774	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	40,439	1,056,568	0	3,098,427	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	301,666	0	315,087	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	920,862	6,563,920	0	548,515	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	7,601,150	36,034,834	0	4,636,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	236,334,105	351,977,512	-21,463,602	77,435,810	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,695	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			ADMITTING (INPATIENT CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS ((SQUARE FEET))	
			5.03	5.04	5A.05	5.05	6.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,709,888	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	411,595	0	192.01
192.02	19202	AUXILIARY	0	0	0	247,052	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,521,819	2,846,517		21,463,602	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006439	0.008087		0.268917	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	103,529	59,989		300,618	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000438	0.000170		0.003766	0.000000	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: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:

2/24/2022 11:41 am

Cost Center Description		OPERATION OF PLANT ((SQUARE FEET))	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING ((SQUARE FEET))	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	
		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
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	215,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,682	309,685			8.00
9.00	00900	HOUSEKEEPING	3,524	0	208,304		9.00
10.00	01000	DIETARY	7,456	0	7,456	103,719	10.00
11.00	01100	CAFETERIA	3,378	0	3,378	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	45,365	12.00
13.00	01300	NURSING ADMINISTRATION	2,413	0	2,413	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,064	0	11,064	0	14.00
15.00	01500	PHARMACY	4,836	0	4,836	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,978	0	4,978	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	153	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,016	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	120	0	120	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,731	99,074	41,731	84,546	30.00
31.00	03100	INTENSIVE CARE UNIT	6,295	13,209	6,295	9,132	31.00
31.01	02060	NICU	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	5,293	0	5,293	10,041	40.00
43.00	04300	NURSERY	3,876	16,535	3,876	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,284	56,083	18,284	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,198	47,186	3,198	0	52.00
53.00	05300	ANESTHESIOLOGY	668	0	668	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,778	22,294	9,778	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	56.01
60.00	06000	LABORATORY	8,165	0	8,165	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,449	0	2,449	0	65.00
66.00	06600	PHYSICAL THERAPY	2,593	5,730	2,593	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,177	0	3,177	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	435	0	435	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	2,133	0	2,133	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	7,902	11,883	7,902	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1,200	494	1,200	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	3,234	1,652	3,234	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	90.05
91.00	09100	EMERGENCY	7,552	35,545	7,552	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,567	309,685	162,361	103,719	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627	0	627	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,316	0	45,316	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			OPERATION OF PLANT ((SQUARE FEET))	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING ((SQUARE FEET))	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	
			7.00	8.00	9.00	10.00	11.00	
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	444	192.02
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)	6,980,236	805,717	2,743,794	3,098,132	867,981	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.389383	2.601731	13.172066	29.870438	19.133275	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	914,326	61,806	75,822	147,368	61,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.242615	0.199577	0.363997	1.420839	1.353687	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: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	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
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	28,273				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,259,132			14.00
15.00	01500	PHARMACY	0	0	0	2,758,330		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	351,977,512	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	14,913	179	289,493	99,379,270	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,335	0	263,282	10,013,989	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	938	0	33,748	6,766,058	40.00
43.00	04300	NURSERY	0	676	0	6,158	2,919,374	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,634	4,075	141,236	20,368,874	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,724	0	76,715	3,251,442	52.00
53.00	05300	ANESTHESIOLOGY	0	111	0	5,869	3,004,098	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,258	29,725,912	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	2,952	58,605,304	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,106	0	1,401	6,073,543	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,197,914	66.00
69.00	06900	ELECTROCARDIOLOGY	0	284	0	0	5,017,969	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	153,225	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	854,947	0	2,657,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,399,580	0	3,974,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,595,341	38,402,565	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	15,408	3,182,932	74.00
75.01	07501	CARDIAC CATH LAB	0	407	0	9,136	11,326,153	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	90,747	1,056,568	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	14,536	301,666	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	20,497	6,563,920	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	3,145	11	180,755	36,034,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	28,273	2,258,792	2,749,532	351,977,512	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	170	8,653	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	170	145	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,764,017	2,320,680	3,020,822	1,832,485	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	62.392282	1.027244	1.095163	0.005206	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	65,374	233,668	201,755	94,622	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.312241	0.103433	0.073144	0.000269	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: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	
			17.00	19.00	20.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	100					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING PROGRAM	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				100	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	87	0	0	90	90	30.00
31.00	03100	INTENSIVE CARE UNIT	4	0	0	0	0	31.00
31.01	02060	NICU	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	10	10	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	6	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	0	100	100	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS		
						SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	
						17.00	19.00	
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROHEALTH SERVICES	0	0	0	0	0	192.01
192.02	19202	AUXILIARY	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,038,010	0	0	1,737,777	7,294	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10,380.100000	0.000000	0.000000	17,377.770000	72.940000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,468	0	0	8,602	1,997	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	74.680000	0.000000	0.000000	86.020000	19.970000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000			207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	01160	COMMUNICATIONS	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00570	ADMITTING	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00505	OTHER ADMINISTRATIVE AND GENERAL	5.05
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
31.01	02060	NICU	31.01
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.01	05601	NUCLEAR MEDICINE	56.01
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.01	07501	CARDIAC CATH LAB	75.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	PH CLINIC	90.01
90.02	09002	HEALTHWORKS CLINIC	90.02
90.03	09003	DENTAL CLINIC	90.03
90.04	09004	WOUND CARE THERAPY	90.04
90.05	09005	FAMILY PRACTICE CLINIC	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
192.01	19201	PROHEALTH SERVICES	0	192.01
192.02	19202	AUXILIARY	0	192.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:41 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:41 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	93,405,861		93,405,861			30.00
31.00	03100	INTENSIVE CARE UNIT	10,013,989		10,013,989			31.00
31.01	02060	NICU	0		0			31.01
40.00	04000	SUBPROVIDER - IPF	6,766,058		6,766,058			40.00
43.00	04300	NURSERY	2,919,374		2,919,374			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,615,468	12,753,406	20,368,874	0.327540	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,615,908	635,534	3,251,442	1.229351	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,526,858	1,477,240	3,004,098	0.096308	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,140,455	17,585,457	29,725,912	0.193591	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000	56.01
60.00	06000	LABORATORY	31,482,396	27,122,908	58,605,304	0.167588	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	5,562,472	511,071	6,073,543	0.324616	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,079,867	2,118,047	3,197,914	0.299730	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	2,723,396	2,294,573	5,017,969	0.154615	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	143,775	9,450	153,225	1.507365	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,895,984	761,468	2,657,452	0.760011	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,459,400	1,515,050	3,974,450	0.829104	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,107,107	6,295,458	38,402,565	0.120509	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,059,636	123,296	3,182,932	0.391280	0.000000	74.00
75.01	07501	CARDIAC CATH LAB	9,069,975	2,256,178	11,326,153	0.122998	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	40,439	1,016,129	1,056,568	4.264911	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	301,666	301,666	1.603598	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	920,862	5,643,058	6,563,920	0.139229	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	7,601,150	28,433,684	36,034,834	0.194940	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,183,675	4,789,734	5,973,409	0.348226	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	236,334,105	115,643,407	351,977,512			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	236,334,105	115,643,407	351,977,512			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	02060	NICU				31.01
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.327540			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.229351			52.00
53.00	05300	ANESTHESIOLOGY	0.096308			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193591			54.00
56.01	05601	NUCLEAR MEDICINE	0.000000			56.01
60.00	06000	LABORATORY	0.167588			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.324616			65.00
66.00	06600	PHYSICAL THERAPY	0.299730			66.00
69.00	06900	ELECTROCARDIOLOGY	0.154615			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.507365			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.760011			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.829104			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.120509			73.00
74.00	07400	RENAL DIALYSIS	0.391280			74.00
75.01	07501	CARDIAC CATH LAB	0.122998			75.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.424589			90.00
90.01	09001	PH CLINIC	0.000000			90.01
90.02	09002	HEALTHWORKS CLINIC	1.603598			90.02
90.03	09003	DENTAL CLINIC	0.000000			90.03
90.04	09004	WOUND CARE THERAPY	0.139229			90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.194940			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.348226			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,590,711		28,590,711	0	28,590,711	30.00
31.00	03100	INTENSIVE CARE UNIT	5,735,032		5,735,032	0	5,735,032	31.00
31.01	02060	NICU	0		0	0	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,078,545		2,078,545	0	2,078,545	40.00
43.00	04300	NURSERY	1,998,000		1,998,000	0	1,998,000	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,671,613		6,671,613	0	6,671,613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,997,163		3,997,163	0	3,997,163	52.00
53.00	05300	ANESTHESIOLOGY	289,319		289,319	0	289,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,754,683		5,754,683	0	5,754,683	54.00
56.01	05601	NUCLEAR MEDICINE	0		0	0	0	56.01
60.00	06000	LABORATORY	9,821,571		9,821,571	0	9,821,571	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,971,569	0	1,971,569	0	1,971,569	65.00
66.00	06600	PHYSICAL THERAPY	958,510	0	958,510	0	958,510	66.00
69.00	06900	ELECTROCARDIOLOGY	775,851		775,851	0	775,851	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	230,966		230,966	0	230,966	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,019,692		2,019,692	0	2,019,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,295,231		3,295,231	0	3,295,231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,627,850		4,627,850	0	4,627,850	73.00
74.00	07400	RENAL DIALYSIS	1,245,418		1,245,418	0	1,245,418	74.00
75.01	07501	CARDIAC CATH LAB	1,393,097		1,393,097	0	1,393,097	75.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,506,168		4,506,168	168,711	4,674,879	90.00
90.01	09001	PH CLINIC	0		0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	483,751		483,751	0	483,751	90.02
90.03	09003	DENTAL CLINIC	0		0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	913,888		913,888	0	913,888	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0		0	0	0	90.05
91.00	09100	EMERGENCY	7,024,631		7,024,631	0	7,024,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,080,095		2,080,095	0	2,080,095	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	96,463,354	0	96,463,354	168,711	96,632,065	200.00
201.00		Less Observation Beds	2,080,095		2,080,095		2,080,095	201.00
202.00		Total (see instructions)	94,383,259	0	94,383,259	168,711	94,551,970	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:41 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	93,405,861		93,405,861		30.00
31.00	03100	INTENSIVE CARE UNIT	10,013,989		10,013,989		31.00
31.01	02060	NICU	0		0		31.01
40.00	04000	SUBPROVIDER - IPF	6,766,058		6,766,058		40.00
43.00	04300	NURSERY	2,919,374		2,919,374		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,615,468	12,753,406	20,368,874	0.327540	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,615,908	635,534	3,251,442	1.229351	0.000000
53.00	05300	ANESTHESIOLOGY	1,526,858	1,477,240	3,004,098	0.096308	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,140,455	17,585,457	29,725,912	0.193591	0.000000
56.01	05601	NUCLEAR MEDICINE	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	31,482,396	27,122,908	58,605,304	0.167588	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	5,562,472	511,071	6,073,543	0.324616	0.000000
66.00	06600	PHYSICAL THERAPY	1,079,867	2,118,047	3,197,914	0.299730	0.000000
69.00	06900	ELECTROCARDIOLOGY	2,723,396	2,294,573	5,017,969	0.154615	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	143,775	9,450	153,225	1.507365	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,895,984	761,468	2,657,452	0.760011	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,459,400	1,515,050	3,974,450	0.829104	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	32,107,107	6,295,458	38,402,565	0.120509	0.000000
74.00	07400	RENAL DIALYSIS	3,059,636	123,296	3,182,932	0.391280	0.000000
75.01	07501	CARDIAC CATH LAB	9,069,975	2,256,178	11,326,153	0.122998	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	40,439	1,016,129	1,056,568	4.264911	0.000000
90.01	09001	PH CLINIC	0	0	0	0.000000	0.000000
90.02	09002	HEALTHWORKS CLINIC	0	301,666	301,666	1.603598	0.000000
90.03	09003	DENTAL CLINIC	0	0	0	0.000000	0.000000
90.04	09004	WOUND CARE THERAPY	920,862	5,643,058	6,563,920	0.139229	0.000000
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	7,601,150	28,433,684	36,034,834	0.194940	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,183,675	4,789,734	5,973,409	0.348226	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	236,334,105	115,643,407	351,977,512		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	236,334,105	115,643,407	351,977,512		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
31.01	02060	NICU				31.01
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.01	05601	NUCLEAR MEDICINE	0.000000			56.01
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.01	07501	CARDIAC CATH LAB	0.000000			75.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	PH CLINIC	0.000000			90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000			90.02
90.03	09003	DENTAL CLINIC	0.000000			90.03
90.04	09004	WOUND CARE THERAPY	0.000000			90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000			90.05
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/24/2022 11:41 am

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,277,264	0	1,277,264	30,280	42.18	30.00	
31.00	INTENSIVE CARE UNIT	199,246		199,246	3,044	65.46	31.00	
31.01	NICU	0		0	0	0.00	31.01	
40.00	SUBPROVIDER - IPF	125,073	0	125,073	3,347	37.37	40.00	
43.00	NURSERY	87,921		87,921	861	102.11	43.00	
200.00	Total (lines 30 through 199)	1,689,504		1,689,504	37,532		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	6,167	260,124					30.00
31.00	INTENSIVE CARE UNIT	684	44,775					31.00
31.01	NICU	0	0					31.01
40.00	SUBPROVIDER - IPF	891	33,297					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	7,742	338,196					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	465,376	20,368,874	0.022847	1,758,615	40,179 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,600	3,251,442	0.097680	17,247	1,685 52.00
53.00	05300	ANESTHESIOLOGY	21,949	3,004,098	0.007306	342,731	2,504 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344,754	29,725,912	0.011598	2,863,721	33,213 54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0 56.01
60.00	06000	LABORATORY	260,407	58,605,304	0.004443	7,098,354	31,538 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	69,688	6,073,543	0.011474	1,264,136	14,505 65.00
66.00	06600	PHYSICAL THERAPY	64,452	3,197,914	0.020154	286,642	5,777 66.00
69.00	06900	ELECTROCARDIOLOGY	80,045	5,017,969	0.015952	607,960	9,698 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,805	153,225	0.096623	37,125	3,587 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	93,774	2,657,452	0.035287	491,987	17,361 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	153,034	3,974,450	0.038504	705,497	27,164 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,568	38,402,565	0.004051	6,826,705	27,655 73.00
74.00	07400	RENAL DIALYSIS	7,461	3,182,932	0.002344	1,198,456	2,809 74.00
75.01	07501	CARDIAC CATH LAB	56,385	11,326,153	0.004978	2,536,927	12,629 75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	196,537	1,056,568	0.186015	15,700	2,920 90.00
90.01	09001	PH CLINIC	0	0	0.000000	0	0 90.01
90.02	09002	HEALTHWORKS CLINIC	23,862	301,666	0.079101	0	0 90.02
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0 90.03
90.04	09004	WOUND CARE THERAPY	65,734	6,563,920	0.010014	127,131	1,273 90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0 90.05
91.00	09100	EMERGENCY	226,083	36,034,834	0.006274	1,915,737	12,019 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92,926	5,973,409	0.015557	244,871	3,809 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0 93.99
200.00		Total (lines 50 through 199)	2,710,440	238,872,230		28,339,542	250,325 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0206		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/24/2022 11:41 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
31.01	02060	NICU	0	0	0	0	0	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
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	30,280	0.00	6,167	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	3,044	0.00	684	31.00		
31.01	02060	NICU		0	0	0.00	0	31.01		
40.00	04000	SUBPROVIDER - IPF	0	0	3,347	0.00	891	40.00		
43.00	04300	NURSERY		0	861	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	37,532		7,742	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	
31.01	02060	NICU	0						31.01	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 11:41 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	20,368,874	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,251,442	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,004,098	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,725,912	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	58,605,304	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,073,543	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,197,914	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,017,969	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	153,225	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,657,452	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,974,450	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,402,565	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,182,932	0.000000	74.00
75.01	07501	CARDIAC CATH LAB	0	0	0	11,326,153	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,056,568	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	301,666	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,563,920	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	36,034,834	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,973,409	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	238,872,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	1,758,615	0	1,687,168	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	17,247	0	536	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	342,731	0	165,714	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,863,721	0	1,893,677	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	7,098,354	0	1,433,885	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	1,264,136	0	56,599	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	286,642	0	1,162	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	607,960	0	433,470	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	37,125	0	2,025	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	491,987	0	230,252	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	705,497	0	219,146	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,826,705	0	1,171,198	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,198,456	0	42,098	0	74.00
75.01	07501	CARDIAC CATH LAB	0.000000	2,536,927	0	661,085	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	15,700	0	144,860	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	127,131	0	1,498,632	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	1,915,737	0	2,019,739	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	244,871	0	505,562	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		28,339,542	0	12,166,808	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/24/2022 11:41 am

			Title XVIII		Hospital		PPS	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.327540	1,687,168	0	0	552,615	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.229351	536	0	0	659	52.00
53.00	05300	ANESTHESIOLOGY	0.096308	165,714	0	0	15,960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193591	1,893,677	0	0	366,599	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	56.01
60.00	06000	LABORATORY	0.167588	1,433,885	2,250	0	240,302	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.324616	56,599	0	0	18,373	65.00
66.00	06600	PHYSICAL THERAPY	0.299730	1,162	0	0	348	66.00
69.00	06900	ELECTROCARDIOLOGY	0.154615	433,470	0	0	67,021	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.507365	2,025	0	0	3,052	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.760011	230,252	0	0	174,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.829104	219,146	0	0	181,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.120509	1,171,198	0	2,516	141,140	73.00
74.00	07400	RENAL DIALYSIS	0.391280	42,098	0	0	16,472	74.00
75.01	07501	CARDIAC CATH LAB	0.122998	661,085	0	0	81,312	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4.264911	144,860	0	0	617,815	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.603598	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.139229	1,498,632	0	0	208,653	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.194940	2,019,739	0	0	393,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.348226	505,562	0	0	176,050	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		12,166,808	2,250	2,516	3,256,788	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		12,166,808	2,250	2,516	3,256,788	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0206		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Prepared: 2/24/2022 11:41 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.01	05601	NUCLEAR MEDICINE	0	0		56.01
60.00	06000	LABORATORY	377	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	303		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.01	07501	CARDIAC CATH LAB	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PH CLINIC	0	0		90.01
90.02	09002	HEALTHWORKS CLINIC	0	0		90.02
90.03	09003	DENTAL CLINIC	0	0		90.03
90.04	09004	WOUND CARE THERAPY	0	0		90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	377	303		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	377	303		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0206

Period:

Worksheet D

Component CCN: 14-S206

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/24/2022 11:41 am

				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	465,376	20,368,874	0.022847	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	317,600	3,251,442	0.097680	0	0	52.00
53.00	05300	ANESTHESIOLOGY	21,949	3,004,098	0.007306	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344,754	29,725,912	0.011598	111,506	1,293	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0.000000	0	0	56.01
60.00	06000	LABORATORY	260,407	58,605,304	0.004443	737,721	3,278	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	69,688	6,073,543	0.011474	0	0	65.00
66.00	06600	PHYSICAL THERAPY	64,452	3,197,914	0.020154	13,511	272	66.00
69.00	06900	ELECTROCARDIOLOGY	80,045	5,017,969	0.015952	47,331	755	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,805	153,225	0.096623	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	93,774	2,657,452	0.035287	1,263	45	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	153,034	3,974,450	0.038504	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,568	38,402,565	0.004051	1,198,315	4,854	73.00
74.00	07400	RENAL DIALYSIS	7,461	3,182,932	0.002344	0	0	74.00
75.01	07501	CARDIAC CATH LAB	56,385	11,326,153	0.004978	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	196,537	1,056,568	0.186015	0	0	90.00
90.01	09001	PH CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	23,862	301,666	0.079101	0	0	90.02
90.03	09003	DENTAL CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	65,734	6,563,920	0.010014	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	226,083	36,034,834	0.006274	354,865	2,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,973,409	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	2,617,514	238,872,230		2,464,512	12,723	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/24/2022 11:41 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE		0	0	0	0	0	56.01
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB		0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	PH CLINIC		0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC		0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC		0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY		0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC		0	0	0	0	0	90.05
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/24/2022 11:41 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	20,368,874	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,251,442	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,004,098	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,725,912	0.000000	54.00
56.01	05601	NUCLEAR MEDICINE	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	58,605,304	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,073,543	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,197,914	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,017,969	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	153,225	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,657,452	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,974,450	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,402,565	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,182,932	0.000000	74.00
75.01	07501	CARDIAC CATH LAB	0	0	0	11,326,153	0.000000	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	1,056,568	0.000000	90.00
90.01	09001	PH CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	HEALTHWORKS CLINIC	0	0	0	301,666	0.000000	90.02
90.03	09003	DENTAL CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	WOUND CARE THERAPY	0	0	0	6,563,920	0.000000	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0	0	0	0	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	36,034,834	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,973,409	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	238,872,230		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0206 Component CCN: 14-S206		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/24/2022 11:41 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	111,506	0	0	0	0	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	737,721	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	13,511	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	47,331	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,263	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,198,315	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
75.01	07501	CARDIAC CATH LAB	0.000000	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	0	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	0	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.000000	0	0	0	0	0	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	354,865	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)			2,464,512	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		30,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		30,280	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)		28,077	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,167	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)		28,590,711	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)		28,590,711	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)		28,590,711	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)		944.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,822,943	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)		5,822,943	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/24/2022 11:41 am	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	5,735,032	3,044	1,884.04	684	1,288,683	43.00
43.01 NICU	0	0	0.00	0	0	43.01
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,128,837	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,240,463	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					304,899	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					250,325	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					555,224	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,685,239	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,203	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					944.21	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,080,095	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,277,264	28,590,711	0.044674	2,080,095	92,926
91.00	Nursing Program cost	0	28,590,711	0.000000	2,080,095	0
92.00	Allied health cost	0	28,590,711	0.000000	2,080,095	0
93.00	All other Medical Education	0	28,590,711	0.000000	2,080,095	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,347	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,347	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,347	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)		891	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)		2,078,545	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)		2,078,545	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)		2,078,545	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)		621.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		553,329	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)		553,329	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/24/2022 11:41 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NICU	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					371,133	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					924,462	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					33,297	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,723	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					46,020	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					878,442	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:

Worksheet D-1

Component CCN: 14-S206

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/24/2022 11:41 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	125,073	2,078,545	0.060173	0	0	90.00
91.00	Nursing Program cost	0	2,078,545	0.000000	0	0	91.00
92.00	Allied health cost	0	2,078,545	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,078,545	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/24/2022 11:41 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	30,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	30,280	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)	28,077	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)	2,134	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)	861	15.00
16.00	Nursery days (title V or XIX only)	768	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)	28,590,711	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)	28,590,711	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)	28,590,711	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)	944.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,014,944	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)	2,014,944	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/24/2022 11:41 am

			Title XIX		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,998,000	861	2,320.56	768	1,782,190	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,735,032	3,044	1,884.04	384	723,471	43.00
43.01	NICU	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,251,213	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,771,818	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,203	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					944.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,080,095	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,277,264	28,590,711	0.044674	2,080,095	92,926	90.00
91.00	Nursing Program cost	0	28,590,711	0.000000	2,080,095	0	91.00
92.00	Allied health cost	0	28,590,711	0.000000	2,080,095	0	92.00
93.00	All other Medical Education	0	28,590,711	0.000000	2,080,095	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/24/2022 11:41 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		21,155,267		30.00
31.00	03100	INTENSIVE CARE UNIT		2,207,492		31.00
31.01	02060	NICU		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.327540	1,758,615	576,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.229351	17,247	21,203	52.00
53.00	05300	ANESTHESIOLOGY	0.096308	342,731	33,008	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193591	2,863,721	554,391	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000	LABORATORY	0.167588	7,098,354	1,189,599	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.324616	1,264,136	410,359	65.00
66.00	06600	PHYSICAL THERAPY	0.299730	286,642	85,915	66.00
69.00	06900	ELECTROCARDIOLOGY	0.154615	607,960	94,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.507365	37,125	55,961	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.760011	491,987	373,916	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.829104	705,497	584,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.120509	6,826,705	822,679	73.00
74.00	07400	RENAL DIALYSIS	0.391280	1,198,456	468,932	74.00
75.01	07501	CARDIAC CATH LAB	0.122998	2,536,927	312,037	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.424589	15,700	69,466	90.00
90.01	09001	PH CLINIC	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.603598	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.139229	127,131	17,700	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100	EMERGENCY	0.194940	1,915,737	373,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.348226	244,871	85,270	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,339,542	6,128,837	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		28,339,542		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/24/2022 11:41 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
31.01	02060 NICU				31.01
40.00	04000 SUBPROVIDER - IPF		6,701,825		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.327540	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.229351	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.096308	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193591	111,506	21,587	54.00
56.01	05601 NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.167588	737,721	123,633	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.324616	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.299730	13,511	4,050	66.00
69.00	06900 ELECTROCARDIOLOGY	0.154615	47,331	7,318	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.507365	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.760011	1,263	960	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.829104	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.120509	1,198,315	144,408	73.00
74.00	07400 RENAL DIALYSIS	0.391280	0	0	74.00
75.01	07501 CARDIAC CATH LAB	0.122998	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	4.424589	0	0	90.00
90.01	09001 PH CLINIC	0.000000	0	0	90.01
90.02	09002 HEALTHWORKS CLINIC	1.603598	0	0	90.02
90.03	09003 DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004 WOUND CARE THERAPY	0.139229	0	0	90.04
90.05	09005 FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100 EMERGENCY	0.194940	354,865	69,177	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.348226	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,464,512	371,133	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,464,512	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/24/2022 11:41 am	
Cost Center Description			Title XIX	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		6,841,266		30.00
31.00	03100	INTENSIVE CARE UNIT		1,221,489		31.00
31.01	02060	NICU		0		31.01
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		106,079		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.327540	563,816	184,672	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.229351	55,345	68,038	52.00
53.00	05300	ANESTHESIOLOGY	0.096308	106,762	10,282	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193591	1,156,292	223,848	54.00
56.01	05601	NUCLEAR MEDICINE	0.000000	0	0	56.01
60.00	06000	LABORATORY	0.167588	2,726,659	456,955	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.324616	673,034	218,478	65.00
66.00	06600	PHYSICAL THERAPY	0.299730	97,133	29,114	66.00
69.00	06900	ELECTROCARDIOLOGY	0.154615	189,908	29,363	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.507365	16,200	24,419	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.760011	229,804	174,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.829104	165,388	137,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.120509	3,135,866	377,900	73.00
74.00	07400	RENAL DIALYSIS	0.391280	171,700	67,183	74.00
75.01	07501	CARDIAC CATH LAB	0.122998	654,892	80,550	75.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4.264911	0	0	90.00
90.01	09001	PH CLINIC	0.000000	0	0	90.01
90.02	09002	HEALTHWORKS CLINIC	1.603598	0	0	90.02
90.03	09003	DENTAL CLINIC	0.000000	0	0	90.03
90.04	09004	WOUND CARE THERAPY	0.139229	171,911	23,935	90.04
90.05	09005	FAMILY PRACTICE CLINIC	0.000000	0	0	90.05
91.00	09100	EMERGENCY	0.194940	588,255	114,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.348226	86,219	30,024	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,789,184	2,251,213	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)		10,789,184		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/24/2022 11:41 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			8,795,230	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			690,281	2.04
3.00	Managed Care Simulated Payments			4,496,589	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			166.96	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)			2.68	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.			1.74	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)			12.44	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)			13.38	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			17.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			3.00	11.00
12.00	Current year allowable FTE (see instructions)			16.38	12.00
13.00	Total allowable FTE count for the prior year.			16.38	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.			15.56	14.00
15.00	Sum of lines 12 through 14 divided by 3.			16.11	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			16.11	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.096490	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.099087	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.096490	21.00
22.00	IME payment adjustment (see instructions)			451,327	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			230,742	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			3.62	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)			451,327	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			230,742	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			22.70	30.00
31.00	Percentage of Medicaid patient days (see instructions)			58.57	31.00
32.00	Sum of lines 30 and 31			81.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)			56.26	33.00
34.00	Disproportionate share adjustment (see instructions)			1,237,049	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/24/2022 11:41 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		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)		0	1,207,894	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,207,894	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,207,894		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		1,334		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		46	112	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		46	112	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	11.84			42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		769		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.695298			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		717.99	759.39	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		82,100		46.00
47.00	Subtotal (see instructions)		12,463,881		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)			12,694,623	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			850,498	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).			452,193	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			97,219	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			14,094,533	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			14,094,533	61.00
62.00	Deductibles billed to program beneficiaries			718,196	62.00
63.00	Coinsurance billed to program beneficiaries			158,486	63.00
64.00	Allowable bad debts (see instructions)			512,214	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			332,939	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			466,712	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			13,550,790	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)			13,263	70.93
70.94	HRR adjustment amount (see instructions)			-48,909	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,515,144	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		13,008,891	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		506,253	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		339,216	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/24/2022 11:41 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,795,230	0	0	8,795,230	8,795,230
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	690,281	0	0	690,281	690,281
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	4,496,589	0	0	4,496,589	4,496,589
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.096490	0.096490	0.096490	0.096490	0.096490
6.00	IME payment adjustment (see instructions)	22.00	451,327	0	0	451,327	451,327
6.01	IME payment adjustment for managed care (see instructions)	22.01	230,742	0	0	230,742	230,742
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	451,327	0	0	451,327	451,327
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	230,742	0	0	230,742	230,742
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5626	0.5626	0.5626	0.5626	0.5626
11.00	Disproportionate share adjustment (see instructions)	34.00	1,237,049	0	0	1,237,049	1,237,049
11.01	Uncompensated care payments	36.00	1,207,894	0	0	1,207,894	1,207,894
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	82,100	0	0	82,100	82,100
13.00	Subtotal (see instructions)	47.00	12,463,881	0	0	12,463,881	12,463,881
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,694,623	0	0	12,694,623	12,694,623
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	850,498	0	0	850,498	850,498

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/24/2022 11:41 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	97,219	0	0	97,219	97,219	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	13,642,340	13,642,340	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	673,616	0	0	673,616	673,616	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,660	0	0	19,660	19,660	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0545	0.0545	0.0545	0.0545		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,712	0	0	36,712	36,712	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1789	0.1789	0.1789	0.1789		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	120,510	0	0	120,510	120,510	25.00
26.00	Total prospective capital payments (see instructions)	12.00	850,498	0	0	850,498	850,498	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/24/2022 11:41 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,795,230		8,795,230	8,795,230	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	690,281		690,281	690,281	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,496,589	0	4,496,589	4,496,589	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.096490	0.096490	0.096490		5.00
6.00	IME payment adjustment (see instructions)	22.00	451,327	0	451,327	451,327	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	230,742	0	230,742	230,742	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	451,327	0	451,327	451,327	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	230,742	0	230,742	230,742	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5626	0.5626	0.5626		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,237,049	0	1,237,049	1,237,049	11.00
11.01	Uncompensated care payments	36.00	1,207,894	0	1,207,894	1,207,894	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	82,100	0	82,100	82,100	12.00
13.00	Subtotal (see instructions)	47.00	12,463,881	0	12,463,881	12,463,881	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,694,623	0	12,694,623	12,694,623	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	850,498	0	850,498	850,498	16.00
17.00	Special add-on payments for new technologies	54.00	97,219	0	97,219	97,219	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	13,642,340	13,642,340	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/24/2022 11:41 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	673,616	0	673,616	673,616	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,660	0	19,660	19,660	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0545	0.0545	0.0545		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,712	0	36,712	36,712	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1789	0.1789	0.1789		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	120,510	0	120,510	120,510	25.00
26.00	Total prospective capital payments (see instructions)	12.00	850,498	0	850,498	850,498	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	13,263	0	13,263	13,263	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-48,909	0	-48,909	-48,909	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		680	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,256,788	2.00
3.00	OPPS payments		2,027,122	3.00
4.00	Outlier payment (see instructions)		65,078	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)		680	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,766	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)		4,766	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)		4,766	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,086	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)		680	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,092,200	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		400,343	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,692,537	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		103,990	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,796,527	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,796,527	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)		157,582	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		102,428	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		123,384	36.00
37.00	Subtotal (see instructions)		1,898,955	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,898,955	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,922,195	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-23,240	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		111	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		111	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		22	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)		89	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)		89	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		89	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		89	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		89	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		89	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/24/2022 11:41 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,048,030		1,998,717	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	06/29/2021	39,139	06/29/2021	76,522	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)		-39,139		-76,522	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)		13,008,891		1,922,195	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		506,253		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		23,240	6.02
7.00	Total Medicare program liability (see instructions)		13,515,144		1,898,955	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0206

Period:

Worksheet E-1

Component CCN: 14-S206

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/24/2022 11:41 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		803,239		89	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)		803,239		89	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		3,054		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		806,293		89	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: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part II Date/Time Prepared: 2/24/2022 11:41 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			886,792 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			9.169863 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			886,792 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			886,792 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			886,792 18.00
19.00	Deductibles			61,112 19.00
20.00	Subtotal (line 18 minus line 19)			825,680 20.00
21.00	Coinsurance			22,441 21.00
22.00	Subtotal (line 20 minus line 21)			803,239 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,698 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			3,054 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			654 25.00
26.00	Subtotal (sum of lines 22 and 24)			806,293 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			806,293 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			803,239 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			3,054 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet E-3
Part VII
Date/Time Prepared:
2/24/2022 11:41 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		6,771,818		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,771,818	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,771,818	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		8,168,834		8.00
9.00	Ancillary service charges		10,789,184	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		18,958,018	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		18,958,018	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		12,186,200	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,771,818	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,771,818	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,771,818	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,771,818	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-2,193,457	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,578,361	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,578,361	0	40.00
41.00	Interim payments		4,578,361	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0206 Component CCN: 14-S206	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 2/24/2022 11:41 am	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0206		Period: From 10/01/2020 To 09/30/2021	Worksheet E-4 Date/Time Prepared: 2/24/2022 11:41 am	
		Title XVIII		Hospital		PPS
						1.00
COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					1.98 1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00 2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00 3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					1.29 3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00 4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					12.44 4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					13.13 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					17.00 6.00
7.00	Enter the lesser of line 5 or line 6					13.13 7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.00	0.00	17.00		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	13.13	0.00	13.13		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.50			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		3.00			10.01
11.00	Total weighted FTE count	13.13	2.50			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	13.13	3.00			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	12.56	3.00			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	12.94	2.83			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	12.94	2.83			17.00
18.00	Per resident amount	105,689.30	105,689.30			18.00
19.00	Approved amount for resident costs	1,367,620	299,101	1,666,721		19.00
				1.00		
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			3.87		21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00
24.00	Multiply line 22 time line 23			0		24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,666,721		25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD						
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	7,742	989	2,967	26.00	
27.00	Total Inpatient Days (see instructions)	34,573	34,573	34,573	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.223932	0.028606	0.085818	28.00	
29.00	Program direct GME amount	373,232	47,678	143,035	563,945	29.00
29.01	Percent reduction for MA DGME		4.07	4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,940	5,822	7,762	30.00
31.00	Net Program direct GME amount				556,183	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0206	Period: From 10/01/2020 To 09/30/2021	Worksheet E-4 Date/Time Prepared: 2/24/2022 11:41 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			3,182,932	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			14,164,925	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			14,164,925	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			3,257,468	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			3,257,468	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			17,422,393	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.813030	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.186970	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			556,183	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			452,193	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			103,990	50.00

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

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/24/2022 11:41 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	39,360,254	0	0	0	1.00
2.00 Temporary investments	26,302,621	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	36,685,906	0	0	0	4.00
5.00 Other receivable	2,296,323	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-26,139,814	0	0	0	6.00
7.00 Inventory	2,199,275	0	0	0	7.00
8.00 Prepaid expenses	661,445	0	0	0	8.00
9.00 Other current assets	1,169,425	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)	82,535,435	0	0	0	11.00
FIXED ASSETS					
12.00 Land	4,840,913	0	0	0	12.00
13.00 Land improvements	3,717,813	0	0	0	13.00
14.00 Accumulated depreciation	52,761,482	0	0	0	14.00
15.00 Buildings	1,184,650	0	0	0	15.00
16.00 Accumulated depreciation	-42,472,645	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	35,232,470	0	0	0	19.00
20.00 Accumulated depreciation	-21,905,851	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	66,476,095	0	0	0	23.00
24.00 Accumulated depreciation	-53,802,156	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	46,032,771	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	6,874,876	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	6,753,665	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	13,628,541	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	142,196,747	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	12,439,523	0	0	0	37.00
38.00 Salaries, wages, and fees payable	5,399,581	0	0	0	38.00
39.00 Payroll taxes payable	1,371,816	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,002,938	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	22,839,445	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	43,053,303	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	26,697,451	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	16,116,398	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	42,813,849	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	85,867,152	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	56,329,595				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)	56,329,595	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	142,196,747	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/24/2022 11:41 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		37,259,445		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,070,150				2.00
3.00	Total (sum of line 1 and line 2)		56,329,595		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		56,329,595		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)		56,329,595		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/24/2022 11:41 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	94,007,745		94,007,745	1.00
2.00	SUBPROVIDER - IPF	6,366,058		6,366,058	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)	100,373,803		100,373,803	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,146,567		10,146,567	11.00
11.01	NICU	0		0	11.01
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)	10,146,567		10,146,567	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	110,520,370		110,520,370	17.00
18.00	Ancillary services	124,625,475	0	124,625,475	18.00
19.00	Outpatient services	0	130,859,283	130,859,283	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	235,145,845	130,859,283	366,005,128	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		121,953,181		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)		121,953,181		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/24/2022 11:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	366,005,128	1.00
2.00	Less contractual allowances and discounts on patients' accounts	250,792,922	2.00
3.00	Net patient revenues (line 1 minus line 2)	115,212,206	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	121,953,181	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,740,975	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	477,858	6.00
7.00	Income from investments	1,619,859	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	195,413	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	404,960	22.00
23.00	Governmental appropriations	0	23.00
24.00	HPH HFS COVID STATE/LOCAL GRANT	500,000	24.00
24.01	HPH HPH HEALTH EQUITY PRIVATE/OTHER	35,000	24.01
24.02	OTHER MISC	317,358	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24.07
24.08	OTHER (SPECIFY)	0	24.08
24.09	OTHER (SPECIFY)	0	24.09
24.10	OTHER (SPECIFY)	0	24.10
24.50	COVID-19 PHE Funding	22,260,677	24.50
25.00	Total other income (sum of lines 6-24)	25,811,125	25.00
26.00	Total (line 5 plus line 25)	19,070,150	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,070,150	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0206

Period:
From 10/01/2020
To 09/30/2021Worksheet L
Parts I-III
Date/Time Prepared:
2/24/2022 11:41 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	673,616	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	19,660	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)	85.55	3.00
4.00	Number of interns & residents (see instructions)	16.11	4.00
5.00	Indirect medical education percentage (see instructions)	5.45	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)	36,712	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	22.70	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	58.57	8.00
9.00	Sum of lines 7 and 8	81.27	9.00
10.00	Allowable disproportionate share percentage (see instructions)	17.89	10.00
11.00	Disproportionate share adjustment (see instructions)	120,510	11.00
12.00	Total prospective capital payments (see instructions)	850,498	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