

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: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/29/2021 11:32 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE SAINT JOSEPH HOSPITAL ELGIN (14-0217) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KEVIN LARKIN
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,006,532	68,325	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	127,216	-4		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	1,133,748	68,321	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:32 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 77 NORTH AIRLITE ST.			PO Box:				1.00	
2.00	City: ELGIN			State: IL		Zip Code: 60123		County: KANE 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PRESENCE SAINT JOSEPH HOSPITAL ELGIN	140217	20994	1	09/01/1966	N P P 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF			PRESENCE SAINT JOSEPH REHAB UNIT	14T217	20994	5	09/01/1997	N P N 5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)						1		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 OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								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.					3	N		23.00

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

MCRIF32 - 16.12.172.7

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:32 pm			
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	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	61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
		1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
						1.00			
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00	
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:32 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N			
				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

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,729,393	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.05	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149013	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 11:32 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: ALEXIAN BROTHERS HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05001				141.00	
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:						142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 11:32 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		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	09/15/2021
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 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		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/03/2021	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 11:32 pm
	Description	Y/N	Y/N	
	0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N	20.00
	Y/N	Date	Y/N	Date
	1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	21.00
			1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-451-8283	PATRICK.GILLILAND@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	129	47,085	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)		129	47,085	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		144	52,560	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	40	14,600		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		184			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,627	1,562	21,085			1.00
2.00	HMO and other (see instructions)	2,740	4,625				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	741	237				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)	6,627	1,562	21,085			7.00
8.00	INTENSIVE CARE UNIT	726	293	2,170			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	7,353	1,855	23,255	0.00	438.64	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	5,163	128	7,489	0.00	40.00	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)			207			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	478.64	27.00
28.00	Observation Bed Days		618	2,656			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,422	1,128	4,445	1.00
2.00 HMO and other (see instructions)			469	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				31		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,422	1,128	4,445	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	391	0	572	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	40,843,622	-2,402,546	38,441,076	995,565.00	38.61
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		92,813	0	92,813	666.00	139.36
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician and Non Physician-Part B		3,638	0	3,638	25.00	145.52
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,363,388	-200,518	3,162,870	84,849.00	37.28
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,865,883	0	1,865,883	11,437.87	163.13
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		478,050	0	478,050	3,760.00	127.14
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	14.00
14.01	Home office salaries		46,857,695	0	46,857,695	694,761.00	67.44
14.02	Related organization salaries		0	0	0	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,374,471	0	8,374,471		17.00
18.00	Wage-related costs (other) (see instructions)						18.00
19.00	Excluded areas		772,174	0	772,174		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		11,080	0	11,080		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		427	0	427		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
25.50	Home office wage-related (core)		0	0	0		25.50
25.51	Related organization wage-related (core)		0	0	0		25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	105,767	0	105,767	4.50	23,503.78	26.00
27.00	Administrative & General	5.00	2,235,300	-15,660	2,219,640	45,703.17	48.57	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	603,368	0	603,368	29,648.93	20.35	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,479,214	0	1,479,214	56,966.00	25.97	33.00
34.00	Dietary	10.00	0	178,972	178,972	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		2,170,297	-1,409,264	761,033	28,223.00	26.96	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,570,606	-889,316	1,681,290	47,025.57	35.75	38.00
39.00	Central Services and Supply	14.00	299,476	0	299,476	13,414.26	22.33	39.00
40.00	Pharmacy	15.00	1,592,765	0	1,592,765	32,268.36	49.36	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/29/2021 11:32 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	44,489,495	-3,811,810	40,677,685	1,080,729.00	37.64	1.00
2.00	Excluded area salaries (see instructions)	3,363,388	-200,518	3,162,870	84,849.00	37.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,126,107	-3,611,292	37,514,815	995,880.00	37.67	3.00
4.00	Subtotal other wages & related costs (see inst.)	49,201,628	0	49,201,628	709,958.87	69.30	4.00
5.00	Subtotal wage-related costs (see inst.)	8,385,551	0	8,385,551	0.00	22.35	5.00
6.00	Total (sum of lines 3 thru 5)	98,713,286	-3,611,292	95,101,994	1,705,838.87	55.75	6.00
7.00	Total overhead cost (see instructions)	11,056,793	-2,135,268	8,921,525	253,253.79	35.23	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2021 11:32 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,819,725	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)		3,715,541	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		63,897	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		17,669	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)		174,490	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		419,599	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		2,831,201	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		28,861	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		87,168	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9,158,151	24.00
Part B - Other than Core Related Cost				
25.00	EMPLOYEE ACTIVITIES & ASSISTANCE PROG			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0217

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 11/29/2021 11:32 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,865,883	9,158,152	1.00
2.00	Hospital	1,865,883	8,374,471	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	783,681	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/29/2021 11:32 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.163937	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			10,065,736	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				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			125,535,684	6.00
7.00	Medicaid cost (line 1 times line 6)			20,579,943	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)			10,514,207	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)			10,514,207	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)	30,037,674	1,842,070	31,879,744	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,924,286	1,842,070	6,766,356	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,924,286	1,842,070	6,766,356	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			3,046,830	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			584,531	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			899,279	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,147,551	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			666,811	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			7,433,167	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,947,374	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet A Date/Time Prepared: 11/29/2021 11:32 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
			1.00	2.00	3.00	4.00	5.00		
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	3,080,749	3,080,749	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,734,061	3,734,061	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	105,767	6,278,903	6,384,670	-247	6,384,423	4.00	
5.01	01160	COMMUNICATIONS	0	0	0	0	0	5.01	
5.02	00560	PURCHASING RECEIVING AND STORES	0	415	415	-13	402	5.02	
5.03	00570	ADMITTING	0	4,582	4,582	-2,604	1,978	5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04	
5.05	00590	OTHER ADMIN AND GENERAL	2,235,300	39,326,884	41,562,184	-1,805,675	39,756,509	5.05	
6.00	00600	MAINTENANCE & REPAIRS	0	2,256,851	2,256,851	-185,965	2,070,886	6.00	
7.00	00700	OPERATION OF PLANT	603,368	2,592,083	3,195,451	-239,406	2,956,045	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	307,457	307,457	0	307,457	8.00	
9.00	00900	HOUSEKEEPING	0	1,853,851	1,853,851	-25,623	1,828,228	9.00	
10.00	01000	DIETARY	0	3,238,034	3,238,034	-1,911,960	1,326,074	10.00	
11.00	01100	CAFETERIA	0	0	0	2,099,288	2,099,288	11.00	
13.00	01300	NURSING ADMINISTRATION	2,570,606	987,298	3,557,904	-753,304	2,804,600	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	299,476	676,014	975,490	-185,287	790,203	14.00	
15.00	01500	PHARMACY	1,592,765	7,694,763	9,287,528	-7,118,158	2,169,370	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00	
23.00	02300	PARAMED ED PRGM-AMBULANCE	200,518	75,747	276,265	-276,265	0	23.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,202,513	1,965,790	13,168,303	-853,805	12,314,498	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,520,351	1,485,469	4,005,820	-442,393	3,563,427	31.00	
41.00	04100	SUBPROVIDER - IRF	3,091,138	566,918	3,658,056	-196,920	3,461,136	41.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,695,476	8,440,334	10,135,810	-7,160,477	2,975,333	50.00	
51.00	05100	RECOVERY ROOM	1,911,665	346,819	2,258,484	-172,969	2,085,515	51.00	
53.00	05300	ANESTHESIOLOGY	59,951	2,150,704	2,210,655	-183,248	2,027,407	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,472,868	916,021	2,388,889	-213,038	2,175,851	54.00	
54.01	03650	VASCULAR LAB	472,780	210,121	682,901	-162,858	520,043	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	763,501	1,473,064	2,236,565	-666,881	1,569,684	55.00	
57.00	05700	CT SCAN	399,678	458,811	858,489	-269,404	589,085	57.00	
58.00	05800	MRI	155,913	170,792	326,705	-18,166	308,539	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,102,607	4,536,216	5,638,823	-1,643,191	3,995,632	59.00	
60.00	06000	LABORATORY	0	5,274,964	5,274,964	-220,433	5,054,531	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	323,639	323,639	0	323,639	62.00	
65.00	06500	RESPIRATORY THERAPY	960,634	284,650	1,245,284	-189,358	1,055,926	65.00	
66.00	06600	PHYSICAL THERAPY	3,330,255	1,472,178	4,802,433	-36,020	4,766,413	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	474,971	100,196	575,167	-25,535	549,632	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,893,854	3,893,854	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,350,519	7,350,519	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,227,853	7,227,853	73.00	
74.00	07400	RENAL DIALYSIS	0	561,694	561,694	0	561,694	74.00	
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	336,461	25,769	362,230	0	362,230	76.02	
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03	
76.97	07697	CARDIAC REHABILITATION	186,325	88,637	274,962	-9,429	265,533	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	60,845	931,443	992,288	-304,127	688,161	76.98	
	OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01	
91.00	09100	EMERGENCY	2,787,186	2,783,148	5,570,334	-277,170	5,293,164	91.00	
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01	
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02	
91.03	09103	NUTRITION COUNSELING	178,972	13,440	192,412	-192,412	0	91.03	
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	1,601,434	1,601,434	-1,601,434	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,771,890	101,475,133	142,247,023	42,549	142,289,572	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	127,482	127,482	-34,809	92,673	194.00	
194.01	07951	MOB	0	189,865	189,865	-7,711	182,154	194.01	
194.02	07952	COMMUNITY WELLNESS	71,732	9,393	81,125	-29	81,096	194.02	
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03	
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04	
200.00		TOTAL (SUM OF LINES 118 through 199)	40,843,622	101,801,873	142,645,495	0	142,645,495	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0217

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

Worksheet A

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,161,374	1,919,375	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,545,111	7,279,172	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	248,501	6,632,924	4.00
5.01	01160	COMMUNICATIONS	105,557	105,557	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	402	5.02
5.03	00570	ADMITTING	546,219	548,197	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	-13,411,341	26,345,168	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	2,070,886	6.00
7.00	00700	OPERATION OF PLANT	3,311,906	6,267,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,164	318,621	8.00
9.00	00900	HOUSEKEEPING	0	1,828,228	9.00
10.00	01000	DIETARY	-1,096	1,324,978	10.00
11.00	01100	CAFETERIA	-325,133	1,774,155	11.00
13.00	01300	NURSING ADMINISTRATION	120,407	2,925,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-34,077	756,126	14.00
15.00	01500	PHARMACY	39,073	2,208,443	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,047	47,047	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-46,361	12,268,137	30.00
31.00	03100	INTENSIVE CARE UNIT	-285,491	3,277,936	31.00
41.00	04100	SUBPROVIDER - IRF	0	3,461,136	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-255	2,975,078	50.00
51.00	05100	RECOVERY ROOM	0	2,085,515	51.00
53.00	05300	ANESTHESIOLOGY	-1,950,000	77,407	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-109,194	2,066,657	54.00
54.01	03650	VASCULAR LAB	0	520,043	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-53,127	1,516,557	55.00
57.00	05700	CT SCAN	0	589,085	57.00
58.00	05800	MRI	0	308,539	58.00
59.00	05900	CARDIAC CATHETERIZATION	-252,876	3,742,756	59.00
60.00	06000	LABORATORY	161,487	5,216,018	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	323,639	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,055,926	65.00
66.00	06600	PHYSICAL THERAPY	0	4,766,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	549,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,893,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,350,519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,227,853	73.00
74.00	07400	RENAL DIALYSIS	0	561,694	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	362,230	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	265,533	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	688,161	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0	90.01
91.00	09100	EMERGENCY	-1,964,115	3,329,049	91.00
91.01	09101	C'VILLE OUT	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,457,968	130,831,604	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	92,673	194.00
194.01	07951	MOB	0	182,154	194.01
194.02	07952	COMMUNITY WELLNESS	0	81,096	194.02
194.03	07953	FUND DEVELOPMENT	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,457,968	131,187,527	200.00

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	2,099,288		1.00
	0		0	2,099,288		
	B - EQUIP DEPR					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,856,582		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,356,794		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
31.00		0.00	0	0		31.00
	0		0	5,213,376		
	C - CONTRACT LABOR					
1.00	OTHER ADMIN AND GENERAL	5.05	0	15,660		1.00
2.00	NURSING ADMINISTRATION	13.00	0	889,316		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	680,332		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	367,725		4.00
5.00	OPERATING ROOM	50.00	0	165,889		5.00
6.00	VASCULAR LAB	54.01	0	37,163		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	738		7.00
8.00	RESPIRATORY THERAPY	65.00	0	34,958		8.00
9.00	EMERGENCY	91.00	0	210,765		9.00
	TOTALS		0	2,402,546		
	D - NUTRITION COUNCELING					
1.00	DIETARY	10.00	178,972	13,440		1.00
	TOTALS		178,972	13,440		
	H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	723,955		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	877,479		2.00
	0		0	1,601,434		
	I - EMS TRAINING COSTS					
1.00	EMERGENCY	91.00	200,518	63,936		1.00
	0		200,518	63,936		
	K - DRUG COSTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	68		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,227,853		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
	0		0	7,227,921		

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,350,519		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
	0		0	7,350,519		
	M - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,893,854		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	2,376		2.00
3.00	DIETARY	10.00	0	2,888		3.00
4.00	PHARMACY	15.00	0	46,208		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
	0		0	3,945,326		
500.00	Grand Total: Increases		379,490	29,917,786		500.00

RECLASSIFICATIONS

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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 - CAFETERIA						
1.00	DIETARY	10.00	0	2,099,288	0		1.00
	0		0	2,099,288			
	B - EQUIP DEPR						
1.00	OTHER ADMIN AND GENERAL	5.05	0	1,782,757	9		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	188,341	9		2.00
3.00	OPERATION OF PLANT	7.00	0	234,215	0		3.00
4.00	HOUSEKEEPING	9.00	0	8,358	0		4.00
5.00	DIETARY	10.00	0	7,972	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	717,912	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	100,661	0		7.00
8.00	PHARMACY	15.00	0	31,736	0		8.00
9.00	PARAMED ED PRGM-AMBULANCE	23.00	0	8,039	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	21,237	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	51,594	0		11.00
12.00	SUBPROVIDER - IRF	41.00	0	6,279	0		12.00
13.00	OPERATING ROOM	50.00	0	512,066	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	23,158	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	156,027	0		15.00
16.00	VASCULAR LAB	54.01	0	55,841	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	623,655	0		17.00
18.00	CT SCAN	57.00	0	216,080	0		18.00
19.00	MRI	58.00	0	15,173	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	239,547	0		20.00
21.00	LABORATORY	60.00	0	71,264	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	31,773	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	17,237	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	12,233	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	7,855	0		25.00
26.00	EMERGENCY	91.00	0	29,918	0		26.00
27.00	MISC NONREIMBURSABLE COST CENTER	194.00	0	34,737	0		27.00
28.00	MOB	194.01	0	7,711	0		28.00
31.00		0.00	0	0	9		31.00
	0		0	5,213,376			
	C - CONTRACT LABOR						
1.00	OTHER ADMIN AND GENERAL	5.05	15,660	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	889,316	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	680,332	0	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	367,725	0	0		4.00
5.00	OPERATING ROOM	50.00	165,889	0	0		5.00
6.00	VASCULAR LAB	54.01	37,163	0	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	738	0	0		7.00
8.00	RESPIRATORY THERAPY	65.00	34,958	0	0		8.00
9.00	EMERGENCY	91.00	210,765	0	0		9.00
	TOTALS		2,402,546	0			
	D - NUTRITION COUNCELING						
1.00	NUTRITION COUNSELING	91.03	178,972	13,440	0		1.00
	TOTALS		178,972	13,440			
	H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,601,434	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,601,434			
	I - EMS TRAINING COSTS						
1.00	PARAMED ED PRGM-AMBULANCE	23.00	200,518	63,936	0		1.00
	0		200,518	63,936			
	K - DRUG COSTS						
1.00	PHARMACY	15.00	0	7,132,630	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,915	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	708	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	527	0		4.00
5.00	OPERATING ROOM	50.00	0	9,435	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	5,042	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,851	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	298	0		8.00
9.00	CT SCAN	57.00	0	44,430	0		9.00
10.00	MRI	58.00	0	151	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	12,450	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	701	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	36	0		13.00
14.00	HYPERBARIC OXYGEN THERAPY	76.98	0	121	0		14.00
15.00	EMERGENCY	91.00	0	554	0		15.00
16.00	MISC NONREIMBURSABLE COST CENTER	194.00	0	72	0		16.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	0		0	7,227,921		
	L - IMPLANTS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,551	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	92	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,370	0	3.00
4.00	SUBPROVIDER - IRF	41.00	0	92	0	4.00
5.00	OPERATING ROOM	50.00	0	5,774,261	0	5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	1,320,490	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	656	0	7.00
8.00	HYPERBARIC OXYGEN THERAPY	76.98	0	239,175	0	8.00
9.00	EMERGENCY	91.00	0	832	0	9.00
	0		0	7,350,519		
	M - BILLABLE SUPPLIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	247	0	1.00
2.00	PURCHASING RECEIVING AND STORES	5.02	0	13	0	2.00
3.00	ADMITTING	5.03	0	2,604	0	3.00
4.00	OTHER ADMIN AND GENERAL	5.05	0	22,918	0	4.00
5.00	OPERATION OF PLANT	7.00	0	5,191	0	5.00
6.00	HOUSEKEEPING	9.00	0	17,265	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	35,392	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	73,143	0	8.00
9.00	PARAMED ED PRGM-AMBULANCE	23.00	0	3,772	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	830,561	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	386,721	0	11.00
12.00	SUBPROVIDER - IRF	41.00	0	190,022	0	12.00
13.00	OPERATING ROOM	50.00	0	864,715	0	13.00
14.00	RECOVERY ROOM	51.00	0	172,969	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	155,048	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,160	0	16.00
17.00	VASCULAR LAB	54.01	0	107,017	0	17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	42,928	0	18.00
19.00	CT SCAN	57.00	0	8,894	0	19.00
20.00	MRI	58.00	0	2,842	0	20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	70,704	0	21.00
22.00	LABORATORY	60.00	0	149,169	0	22.00
23.00	RESPIRATORY THERAPY	65.00	0	156,228	0	23.00
24.00	PHYSICAL THERAPY	66.00	0	18,783	0	24.00
25.00	ELECTROCARDIOLOGY	69.00	0	13,266	0	25.00
26.00	CARDIAC REHABILITATION	76.97	0	1,574	0	26.00
27.00	HYPERBARIC OXYGEN THERAPY	76.98	0	64,831	0	27.00
28.00	EMERGENCY	91.00	0	510,320	0	28.00
29.00	COMMUNITY WELLNESS	194.02	0	29	0	29.00
	0		0	3,945,326		
500.00	Grand Total: Decreases		2,782,036	27,515,240		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
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		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	5,020,000	0	0	0	0	1.00	
2.00	Land Improvements	1,277,494	885,723	0	885,723	0	2.00	
3.00	Buildings and Fixtures	54,752,169	0	0	0	2,757,514	3.00	
4.00	Building Improvements	15,000	0	0	0	0	4.00	
5.00	Fixed Equipment	500,032	417,158	0	417,158	0	5.00	
6.00	Movable Equipment	14,984,044	4,183,135	0	4,183,135	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	76,548,739	5,486,016	0	5,486,016	2,757,514	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	76,548,739	5,486,016	0	5,486,016	2,757,514	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,020,000	0				1.00	
2.00	Land Improvements	2,163,217	0				2.00	
3.00	Buildings and Fixtures	51,994,655	0				3.00	
4.00	Building Improvements	15,000	0				4.00	
5.00	Fixed Equipment	917,190	0				5.00	
6.00	Movable Equipment	19,167,179	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	79,277,241	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	79,277,241	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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Part III
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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	53,587,172	0	53,587,172	0.727380	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,084,369	0	20,084,369	0.272620	0	2.00
3.00	Total (sum of lines 1-2)	73,671,541	0	73,671,541	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,892,743	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,196,612	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,089,355	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	26,632	0	0	0	1,919,375	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,082,560	0	0	0	7,279,172	2.00
3.00	Total (sum of lines 1-2)	4,109,192	0	0	0	9,198,547	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-723,955	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-877,479	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,816,405			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	-3,180,549			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-322,888	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,245	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-464,051	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	340,030	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE	B	-168	OPERATION OF PLANT	7.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

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

Worksheet A-8

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.01	MISC REVENUE	B	-280	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
34.02	MISC REVENUE	B	-237,699	OTHER ADMIN AND GENERAL	5.05	0	34.02
34.03	PARAMEDIC PROGRAM	B	-82,329	EMERGENCY	91.00	0	34.03
34.05	MISC REVENUE	B	-27,645	ADULTS & PEDIATRICS	30.00	0	34.05
34.06	MISC REVENUE	B	-34,077	CENTRAL SERVICES & SUPPLY	14.00	0	34.06
34.07	CHARITABLE EXPENSE	A	-1,175	OTHER ADMIN AND GENERAL	5.05	0	34.07
34.08	INCOME TAX FEDERAL	A	-4,107	OTHER ADMIN AND GENERAL	5.05	0	34.08
34.10	MARKETING	A	-255	OPERATING ROOM	50.00	0	34.10
35.00	MARKETING	A	-11,750	OTHER ADMIN AND GENERAL	5.05	0	35.00
35.10	PROMOTIONAL ITEMS	A	-9,845	RADIOLOGY-DIAGNOSTIC	54.00	0	35.10
36.00	PROMOTIONAL ITEMS	A	-1,096	DIETARY	10.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
46.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.00
47.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	47.00
48.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	48.00
49.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,457,968				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 11:32 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	26,632	0 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	INTEREST EXPENSE	4,082,560	0 2.00
3.00		4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS DEPARTMENT	248,781	0 3.00
3.01		5.01	COMMUNICATIONS	COMMUNICATIONS	105,557	0 3.01
3.02		5.03	ADMITTING	ADMITTING	546,219	0 3.02
3.03		5.05	OTHER ADMIN AND GENERAL	OTHER ADMIN AND GENERAL	8,514,968	20,920,596 3.03
3.04		7.00	OPERATION OF PLANT	OPERATION OF PLANT	3,312,074	0 3.04
3.05		8.00	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE	11,164	0 3.05
3.06		13.00	NURSING ADMINISTRATION	NURSING ADMINISTRATION	120,407	0 3.06
3.07		15.00	PHARMACY	PHARMACY	39,073	0 3.07
3.08		16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS & LIBRARY	47,047	0 3.08
3.09		31.00	INTENSIVE CARE UNIT	INTENSIVE CARE UNIT	524,078	0 3.09
3.10		0.00			0	0 3.10
3.11		0.00			0	0 3.11
3.12		0.00			0	0 3.12
3.13		0.00			0	0 3.13
3.14		0.00			0	0 3.14
3.15		0.00			0	0 3.15
3.16		0.00			0	0 3.16
3.17		0.00			0	0 3.17
3.18		0.00			0	0 3.18
4.00		0.00			0	0 4.00
4.01		0.00			0	0 4.01
4.02		0.00			0	0 4.02
4.03		0.00			0	0 4.03
4.04		0.00			0	0 4.04
4.05		0.00			0	0 4.05
4.06		0.00			0	0 4.06
4.07		0.00			0	0 4.07
4.08		0.00			0	0 4.08
4.09		0.00			0	0 4.09
4.10		60.00	LABORATORY	LAB	5,105,437	4,943,950 4.10
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		22,683,997	25,864,546 5.00

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

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

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

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

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

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

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

Provider CCN: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 11:32 pm

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

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

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

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

Provider CCN: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2021 11:32 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	26,632	11		1.00
2.00	4,082,560	11		2.00
3.00	248,781	0		3.00
3.01	105,557	0		3.01
3.02	546,219	0		3.02
3.03	-12,405,628	0		3.03
3.04	3,312,074	0		3.04
3.05	11,164	0		3.05
3.06	120,407	0		3.06
3.07	39,073	0		3.07
3.08	47,047	0		3.08
3.09	524,078	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	161,487	0		4.10
5.00	-3,180,549			5.00

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

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	LABORATORY		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0217

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 11:32 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER ADMIN AND GENERAL	769,387	742,412	26,975	211,500	181	1.00
2.00	30.00	ADULTS & PEDIATRICS	54,000	0	54,000	179,000	410	2.00
3.00	31.00	INTENSIVE CARE UNIT	821,531	800,718	20,813	179,000	139	3.00
4.00	41.00	SUBPROVIDER - IRF	80,820	0	80,820	211,500	896	4.00
5.00	53.00	ANESTHESIOLOGY	1,950,000	1,950,000	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	190,331	87,929	102,402	271,900	696	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	152,867	17,702	135,165	271,900	763	7.00
8.00	59.00	CARDIAC CATHETERIZATION	311,445	227,332	84,113	211,500	576	8.00
9.00	60.00	LABORATORY	36,000	0	36,000	260,300	430	9.00
10.00	91.00	EMERGENCY	1,939,542	1,867,567	71,975	211,500	568	10.00
200.00			6,305,923	5,693,660	612,263		4,659	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	OTHER ADMIN AND GENERAL	18,405	920	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	35,284	1,764	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	11,962	598	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	91,108	4,555	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	90,982	4,549	0	0	0	6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	99,740	4,987	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	58,569	2,928	0	0	0	8.00
9.00	60.00	LABORATORY	53,812	2,691	0	0	0	9.00
10.00	91.00	EMERGENCY	57,756	2,888	0	0	0	10.00
200.00			517,618	25,880	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	OTHER ADMIN AND GENERAL	0	18,405	8,570	750,982		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	35,284	18,716	18,716		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	11,962	8,851	809,569		3.00
4.00	41.00	SUBPROVIDER - IRF	0	91,108	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,950,000		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	90,982	11,420	99,349		6.00
7.00	55.00	RADIOLOGY-THERAPEUTIC	0	99,740	35,425	53,127		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	58,569	25,544	252,876		8.00
9.00	60.00	LABORATORY	0	53,812	0	0		9.00
10.00	91.00	EMERGENCY	0	57,756	14,219	1,881,786		10.00
200.00			0	517,618	122,745	5,816,405		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,919,375	1,919,375			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	7,279,172	7,279,172			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,632,924	0	6,632,924		4.00
5.01	01160	COMMUNICATIONS	105,557	628	0	108,565	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	402	0	0	1,699	5.02
5.03	00570	ADMITTING	548,197	10,362	39,296	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	3,965	5.04
5.05	00590	OTHER ADMIN AND GENERAL	26,345,168	649,301	2,462,466	384,051	5.05
6.00	00600	MAINTENANCE & REPAIRS	2,070,886	5,943	22,540	0	6.00
7.00	00700	OPERATION OF PLANT	6,267,951	372,696	1,413,437	104,397	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	318,621	5,007	18,990	0	8.00
9.00	00900	HOUSEKEEPING	1,828,228	40,398	153,208	0	9.00
10.00	01000	DIETARY	1,324,978	71,090	269,607	30,966	10.00
11.00	01100	CAFETERIA	1,774,155	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,925,007	6,911	26,211	290,904	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	756,126	41,773	158,421	51,817	14.00
15.00	01500	PHARMACY	2,208,443	11,070	41,982	275,587	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,047	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,268,137	149,779	568,032	1,820,584	30.00
31.00	03100	INTENSIVE CARE UNIT	3,277,936	29,065	110,229	372,456	31.00
41.00	04100	SUBPROVIDER - IRF	3,461,136	81,859	310,446	534,841	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,975,078	48,288	183,129	264,655	50.00
51.00	05100	RECOVERY ROOM	2,085,515	38,326	145,349	330,764	51.00
53.00	05300	ANESTHESIOLOGY	77,407	607	2,301	10,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,066,657	52,495	199,087	254,842	54.00
54.01	03650	VASCULAR LAB	520,043	6,817	25,852	75,372	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,516,557	117,596	445,981	132,104	55.00
57.00	05700	CT SCAN	589,085	7,911	30,001	69,154	57.00
58.00	05800	MRI	308,539	8,303	31,490	26,977	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,742,756	11,698	44,363	190,650	59.00
60.00	06000	LABORATORY	5,216,018	26,688	101,212	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	323,639	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,055,926	8,282	31,410	160,164	65.00
66.00	06600	PHYSICAL THERAPY	4,766,413	21,232	80,520	576,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	549,632	22,799	86,465	82,181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,893,854	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,350,519	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,227,853	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	561,694	975	3,697	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	362,230	10,239	38,831	58,216	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	265,533	0	0	32,239	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	688,161	0	0	10,528	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,329,049	59,238	224,659	480,477	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,831,604	1,917,376	7,271,592	6,620,513	101,957
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	92,673	0	0	0	194.00
194.01	07951	MOB	182,154	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	81,096	1,999	7,580	12,411	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

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	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,187,527	1,919,375	7,279,172	6,632,924	108,565	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN 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	00560	PURCHASING RECEIVING AND STORES	2,101					5.02
5.03	00570	ADMITTING	1	600,877				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	3,965			5.04
5.05	00590	OTHER ADMIN AND GENERAL	95	0	0	29,858,071	29,858,071	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	2,099,558	618,662	6.00
7.00	00700	OPERATION OF PLANT	48	0	0	8,162,305	2,405,129	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	342,807	101,013	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,022,212	595,871	9.00
10.00	01000	DIETARY	4	0	0	1,699,100	500,662	10.00
11.00	01100	CAFETERIA	0	0	0	1,774,533	522,889	11.00
13.00	01300	NURSING ADMINISTRATION	9	0	0	3,253,007	958,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	122	0	0	1,009,203	297,375	14.00
15.00	01500	PHARMACY	27	0	0	2,538,431	747,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	50,823	14,976	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	359	82,277	525	14,905,742	4,392,200	30.00
31.00	03100	INTENSIVE CARE UNIT	147	16,128	107	3,807,390	1,121,897	31.00
41.00	04100	SUBPROVIDER - IRF	79	21,178	140	4,412,134	1,300,093	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	791	60,186	399	3,538,379	1,042,629	50.00
51.00	05100	RECOVERY ROOM	17	28,285	188	2,629,577	774,839	51.00
53.00	05300	ANESTHESIOLOGY	36	11,603	77	102,970	30,341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25	20,316	135	2,600,165	766,172	54.00
54.01	03650	VASCULAR LAB	15	9,107	60	637,455	187,834	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	16	13,980	93	2,232,180	657,741	55.00
57.00	05700	CT SCAN	13	40,413	268	736,845	217,121	57.00
58.00	05800	MRI	0	9,149	61	384,519	113,304	58.00
59.00	05900	CARDIAC CATHETERIZATION	143	36,029	239	4,025,878	1,186,277	59.00
60.00	06000	LABORATORY	60	46,053	305	5,394,112	1,589,445	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,262	8	325,098	95,794	62.00
65.00	06500	RESPIRATORY THERAPY	9	6,011	40	1,263,164	372,208	65.00
66.00	06600	PHYSICAL THERAPY	14	27,935	185	5,474,590	1,613,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6	15,810	105	758,320	223,449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,961	146	3,915,961	1,153,889	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,536	256	7,389,311	2,177,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,987	239	7,264,079	2,140,455	73.00
74.00	07400	RENAL DIALYSIS	0	2,074	14	568,454	167,502	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,691	24	476,441	140,390	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1	1,186	8	298,967	88,095	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6	4,417	29	703,141	207,190	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	56	47,303	314	4,148,082	1,222,286	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,099	600,877	3,965	130,803,004	29,744,767	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	378	111	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	1	0	0	92,674	27,308	194.00
194.01	07951	MOB	0	0	0	187,629	55,287	194.01
194.02	07952	COMMUNITY WELLNESS	1	0	0	103,087	30,376	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	755	222	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	2,101	600,877	3,965	131,187,527	29,858,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet 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	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	2,718,220					6.00
7.00	00700	OPERATION OF PLANT	808,427	11,375,861				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,861	64,697	519,378			8.00
9.00	00900	HOUSEKEEPING	87,629	521,967	0	3,227,679		9.00
10.00	01000	DIETARY	154,204	918,528	0	274,785	3,547,279	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	14,991	89,298	0	26,714	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,610	539,727	0	161,464	0	14.00
15.00	01500	PHARMACY	24,012	143,030	0	42,789	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	324,890	1,935,235	356,203	578,941	2,432,812	30.00
31.00	03100	INTENSIVE CARE UNIT	63,046	375,539	36,659	112,346	250,377	31.00
41.00	04100	SUBPROVIDER - IRF	177,562	1,057,662	126,516	316,409	864,090	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,742	623,905	0	186,646	0	50.00
51.00	05100	RECOVERY ROOM	83,133	495,192	0	148,141	0	51.00
53.00	05300	ANESTHESIOLOGY	1,316	7,838	0	2,345	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,869	678,272	0	202,911	0	54.00
54.01	03650	VASCULAR LAB	14,786	88,074	0	26,348	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	255,082	1,519,418	0	454,547	0	55.00
57.00	05700	CT SCAN	17,159	102,210	0	30,577	0	57.00
58.00	05800	MRI	18,011	107,284	0	32,095	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,374	151,140	0	45,215	0	59.00
60.00	06000	LABORATORY	57,889	344,822	0	103,156	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	17,965	107,012	0	32,014	0	65.00
66.00	06600	PHYSICAL THERAPY	46,054	274,326	0	82,067	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	49,454	294,578	0	88,125	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,114	12,595	0	3,768	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	22,209	132,293	0	39,576	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	128,496	765,395	0	228,974	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,713,885	11,350,037	519,378	3,219,953	3,547,279	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	4,335	25,824	0	7,726	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	2,718,220	11,375,861	519,378	3,227,679	3,547,279	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN 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	2,297,422					11.00
13.00	01300	NURSING ADMINISTRATION	117,913	4,460,464				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,634	0	2,132,013			14.00
15.00	01500	PHARMACY	80,909	0	0	3,577,153		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	65,799	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	728,826	1,999,494	0	0	8,713	30.00
31.00	03100	INTENSIVE CARE UNIT	120,358	479,730	0	0	1,775	31.00
41.00	04100	SUBPROVIDER - IRF	208,611	565,215	0	0	2,331	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	97,844	169,087	0	0	6,625	50.00
51.00	05100	RECOVERY ROOM	121,968	392,119	0	0	3,114	51.00
53.00	05300	ANESTHESIOLOGY	3,731	0	0	0	1,277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,554	52,366	0	0	2,236	54.00
54.01	03650	VASCULAR LAB	22,930	25,090	0	0	1,003	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	49,586	102,090	0	0	1,539	55.00
57.00	05700	CT SCAN	28,527	962	0	0	4,449	57.00
58.00	05800	MRI	9,418	597	0	0	1,007	58.00
59.00	05900	CARDIAC CATHETERIZATION	53,892	105,917	0	0	3,966	59.00
60.00	06000	LABORATORY	0	0	0	0	5,070	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	139	62.00
65.00	06500	RESPIRATORY THERAPY	60,356	0	0	0	662	65.00
66.00	06600	PHYSICAL THERAPY	205,966	0	0	0	3,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,655	33,281	0	0	1,740	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	738,302	0	2,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,393,711	0	4,242	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,577,153	3,961	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	228	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	25,829	19,713	0	0	406	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	12,196	24,492	0	0	131	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,147	16,747	0	0	486	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	173,432	471,964	0	0	5,207	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,293,282	4,458,864	2,132,013	3,577,153	65,799	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	4,140	1,600	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	2,297,422	4,460,464	2,132,013	3,577,153	65,799	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMIN 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
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
23.00	02300	PARAMED ED PRGM-AMBULANCE	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	27,663,056	0	27,663,056	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,369,117	0	6,369,117	31.00
41.00	04100	SUBPROVIDER - IRF	0	9,030,623	0	9,030,623	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,769,857	0	5,769,857	50.00
51.00	05100	RECOVERY ROOM	0	4,648,083	0	4,648,083	51.00
53.00	05300	ANESTHESIOLOGY	0	149,818	0	149,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,514,545	0	4,514,545	54.00
54.01	03650	VASCULAR LAB	0	1,003,520	0	1,003,520	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,272,183	0	5,272,183	55.00
57.00	05700	CT SCAN	0	1,137,850	0	1,137,850	57.00
58.00	05800	MRI	0	666,235	0	666,235	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,597,659	0	5,597,659	59.00
60.00	06000	LABORATORY	0	7,494,494	0	7,494,494	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	421,031	0	421,031	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,853,381	0	1,853,381	65.00
66.00	06600	PHYSICAL THERAPY	0	7,699,237	0	7,699,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,483,602	0	1,483,602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,810,569	0	5,810,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,964,621	0	10,964,621	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,985,648	0	12,985,648	73.00
74.00	07400	RENAL DIALYSIS	0	754,661	0	754,661	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	856,857	0	856,857	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	423,881	0	423,881	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	931,711	0	931,711	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	7,143,836	0	7,143,836	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	130,646,075	0	130,646,075	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	489	0	489	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	119,982	0	119,982	194.00
194.01	07951	MOB	0	242,916	0	242,916	194.01
194.02	07952	COMMUNITY WELLNESS	0	177,088	0	177,088	194.02
194.03	07953	FUND DEVELOPMENT	0	977	0	977	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	131,187,527	0	131,187,527	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	01160	COMMUNICATIONS	0	628	2,380	3,008	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	5.02
5.03	00570	ADMITTING	0	10,362	39,296	49,658	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	649,301	2,462,466	3,111,767	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	5,943	22,540	28,483	6.00
7.00	00700	OPERATION OF PLANT	0	372,696	1,413,437	1,786,133	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,007	18,990	23,997	8.00
9.00	00900	HOUSEKEEPING	0	40,398	153,208	193,606	9.00
10.00	01000	DIETARY	0	71,090	269,607	340,697	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,911	26,211	33,122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,773	158,421	200,194	14.00
15.00	01500	PHARMACY	0	11,070	41,982	53,052	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	149,779	568,032	717,811	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,065	110,229	139,294	31.00
41.00	04100	SUBPROVIDER - IRF	0	81,859	310,446	392,305	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	48,288	183,129	231,417	50.00
51.00	05100	RECOVERY ROOM	0	38,326	145,349	183,675	51.00
53.00	05300	ANESTHESIOLOGY	0	607	2,301	2,908	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,495	199,087	251,582	54.00
54.01	03650	VASCULAR LAB	0	6,817	25,852	32,669	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	117,596	445,981	563,577	55.00
57.00	05700	CT SCAN	0	7,911	30,001	37,912	57.00
58.00	05800	MRI	0	8,303	31,490	39,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,698	44,363	56,061	59.00
60.00	06000	LABORATORY	0	26,688	101,212	127,900	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,282	31,410	39,692	65.00
66.00	06600	PHYSICAL THERAPY	0	21,232	80,520	101,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,799	86,465	109,264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	975	3,697	4,672	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	10,239	38,831	49,070	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	59,238	224,659	283,897	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,917,376	7,271,592	9,188,968	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	194.00
194.01	07951	MOB	2,797	0	0	2,797	194.01
194.02	07952	COMMUNITY WELLNESS	1,021	1,999	7,580	10,600	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	3,818	1,919,375	7,279,172	9,202,365	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			COMMUNICATIONS	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN 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	3,008					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	47	47				5.02
5.03	00570	ADMITTING	84	0	49,742			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	110	0	0	110		5.04
5.05	00590	OTHER ADMIN AND GENERAL	469	2	0	0	3,112,238	5.05
6.00	00600	MAINTENANCE & REPAIRS	5	0	0	0	64,486	6.00
7.00	00700	OPERATION OF PLANT	105	1	0	0	250,697	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5	0	0	0	10,529	8.00
9.00	00900	HOUSEKEEPING	10	0	0	0	62,110	9.00
10.00	01000	DIETARY	68	0	0	0	52,186	10.00
11.00	01100	CAFETERIA	10	0	0	0	54,503	11.00
13.00	01300	NURSING ADMINISTRATION	110	0	0	0	99,913	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26	3	0	0	30,997	14.00
15.00	01500	PHARMACY	37	1	0	0	77,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	105	0	0	0	1,561	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	445	8	7,097	110	457,822	30.00
31.00	03100	INTENSIVE CARE UNIT	37	3	1,326	0	116,940	31.00
41.00	04100	SUBPROVIDER - IRF	68	2	1,741	0	135,514	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	162	20	4,949	0	108,678	50.00
51.00	05100	RECOVERY ROOM	31	0	2,326	0	80,765	51.00
53.00	05300	ANESTHESIOLOGY	16	1	954	0	3,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183	1	1,671	0	79,861	54.00
54.01	03650	VASCULAR LAB	5	0	749	0	19,579	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	162	0	1,150	0	68,559	55.00
57.00	05700	CT SCAN	0	0	3,323	0	22,631	57.00
58.00	05800	MRI	0	0	752	0	11,810	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3	2,963	0	123,651	59.00
60.00	06000	LABORATORY	105	1	3,787	0	165,675	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5	0	104	0	9,985	62.00
65.00	06500	RESPIRATORY THERAPY	37	0	494	0	38,797	65.00
66.00	06600	PHYSICAL THERAPY	58	0	2,297	0	168,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37	0	1,300	0	23,291	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,806	0	120,275	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,169	0	226,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,959	0	223,109	73.00
74.00	07400	RENAL DIALYSIS	0	0	171	0	17,459	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	89	0	303	0	14,633	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	98	0	9,182	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	363	0	21,596	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	194	1	3,890	0	127,404	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,825	47	49,742	110	3,100,428	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10	0	0	0	12	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	2,846	194.00
194.01	07951	MOB	152	0	0	0	5,763	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	3,166	194.02
194.03	07953	FUND DEVELOPMENT	21	0	0	0	23	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	3,008	47	49,742	110	3,112,238	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

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	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	92,974					6.00
7.00	00700	OPERATION OF PLANT	27,652	2,064,588				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	372	11,742	46,645			8.00
9.00	00900	HOUSEKEEPING	2,997	94,731	0	353,454		9.00
10.00	01000	DIETARY	5,274	166,702	0	30,091	595,018	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	513	16,206	0	2,925	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,099	97,954	0	17,681	0	14.00
15.00	01500	PHARMACY	821	25,958	0	4,686	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,113	351,224	31,991	63,400	408,078	30.00
31.00	03100	INTENSIVE CARE UNIT	2,156	68,156	3,292	12,303	41,998	31.00
41.00	04100	SUBPROVIDER - IRF	6,073	191,954	11,362	34,649	144,942	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,583	113,232	0	20,439	0	50.00
51.00	05100	RECOVERY ROOM	2,843	89,872	0	16,222	0	51.00
53.00	05300	ANESTHESIOLOGY	45	1,422	0	257	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,895	123,099	0	22,220	0	54.00
54.01	03650	VASCULAR LAB	506	15,984	0	2,885	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	8,725	275,757	0	49,776	0	55.00
57.00	05700	CT SCAN	587	18,550	0	3,348	0	57.00
58.00	05800	MRI	616	19,471	0	3,515	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	868	27,430	0	4,951	0	59.00
60.00	06000	LABORATORY	1,980	62,581	0	11,296	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	614	19,421	0	3,506	0	65.00
66.00	06600	PHYSICAL THERAPY	1,575	49,787	0	8,987	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,692	53,462	0	9,650	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	72	2,286	0	413	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	760	24,010	0	4,334	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,395	138,910	0	25,074	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,826	2,059,901	46,645	352,608	595,018	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	148	4,687	0	846	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	92,974	2,064,588	46,645	353,454	595,018	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN 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	54,513					11.00
13.00	01300	NURSING ADMINISTRATION	2,798	155,587				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	798	0	350,752			14.00
15.00	01500	PHARMACY	1,920	0	0	164,440		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,666	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,294	69,743	0	0	291	30.00
31.00	03100	INTENSIVE CARE UNIT	2,856	16,734	0	0	43	31.00
41.00	04100	SUBPROVIDER - IRF	4,950	19,715	0	0	56	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,322	5,898	0	0	160	50.00
51.00	05100	RECOVERY ROOM	2,894	13,678	0	0	75	51.00
53.00	05300	ANESTHESIOLOGY	89	0	0	0	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,338	1,827	0	0	54	54.00
54.01	03650	VASCULAR LAB	544	875	0	0	24	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,177	3,561	0	0	37	55.00
57.00	05700	CT SCAN	677	34	0	0	107	57.00
58.00	05800	MRI	223	21	0	0	24	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,279	3,695	0	0	96	59.00
60.00	06000	LABORATORY	0	0	0	0	122	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	3	62.00
65.00	06500	RESPIRATORY THERAPY	1,432	0	0	0	16	65.00
66.00	06600	PHYSICAL THERAPY	4,887	0	0	0	74	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	822	1,161	0	0	42	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	121,465	0	58	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	229,287	0	102	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	164,440	95	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	6	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	613	688	0	0	10	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	289	854	0	0	3	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	98	584	0	0	12	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,115	16,463	0	0	125	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,415	155,531	350,752	164,440	1,666	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	98	56	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	54,513	155,587	350,752	164,440	1,666	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMIN 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
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
23.00	02300	PARAMED ED PRGM-AMBULANCE	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		2,136,427	0	2,136,427	30.00
31.00	03100	INTENSIVE CARE UNIT		405,138	0	405,138	31.00
41.00	04100	SUBPROVIDER - IRF		943,331	0	943,331	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		490,860	0	490,860	50.00
51.00	05100	RECOVERY ROOM		392,381	0	392,381	51.00
53.00	05300	ANESTHESIOLOGY		8,886	0	8,886	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		486,731	0	486,731	54.00
54.01	03650	VASCULAR LAB		73,820	0	73,820	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		972,481	0	972,481	55.00
57.00	05700	CT SCAN		87,169	0	87,169	57.00
58.00	05800	MRI		76,225	0	76,225	58.00
59.00	05900	CARDIAC CATHETERIZATION		220,997	0	220,997	59.00
60.00	06000	LABORATORY		373,447	0	373,447	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		10,097	0	10,097	62.00
65.00	06500	RESPIRATORY THERAPY		104,009	0	104,009	65.00
66.00	06600	PHYSICAL THERAPY		337,564	0	337,564	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		200,721	0	200,721	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		243,604	0	243,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		459,513	0	459,513	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		390,603	0	390,603	73.00
74.00	07400	RENAL DIALYSIS		25,079	0	25,079	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		94,510	0	94,510	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		10,426	0	10,426	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		22,653	0	22,653	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	90.01
91.00	09100	EMERGENCY		604,468	0	604,468	91.00
91.01	09101	C'VILLE OUT		0	0	0	91.01
91.02	09102	LAKE HILL OUT		0	0	0	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	91.03
91.04	09104	HUNTLEY OP		0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,171,140	0	9,171,140	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		22	0	22	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER		2,846	0	2,846	194.00
194.01	07951	MOB		8,712	0	8,712	194.01
194.02	07952	COMMUNITY WELLNESS		19,601	0	19,601	194.02
194.03	07953	FUND DEVELOPMENT		44	0	44	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT		0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	9,202,365	0	9,202,365	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHONES)	PURCHASING RECEIVING AND STORES (PURCH REQUIS)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	547,381					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		547,381				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	38,335,309			4.00
5.01	01160	COMMUNICATIONS	179	179	0	575		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	0	0	9	1,839,216	5.02
5.03	00570	ADMITTING	2,955	2,955	0	16	797	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	21	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	185,173	185,173	2,219,640	90	82,973	5.05
6.00	00600	MAINTENANCE & REPAIRS	1,695	1,695	0	1	2	6.00
7.00	00700	OPERATION OF PLANT	106,288	106,288	603,368	20	41,925	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,428	1,428	0	1	0	8.00
9.00	00900	HOUSEKEEPING	11,521	11,521	0	2	393	9.00
10.00	01000	DIETARY	20,274	20,274	178,972	13	3,238	10.00
11.00	01100	CAFETERIA	0	0	0	2	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,971	1,971	1,681,290	21	8,304	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,913	11,913	299,476	5	106,507	14.00
15.00	01500	PHARMACY	3,157	3,157	1,592,765	7	23,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	20	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,715	42,715	10,522,181	85	314,558	30.00
31.00	03100	INTENSIVE CARE UNIT	8,289	8,289	2,152,626	7	128,787	31.00
41.00	04100	SUBPROVIDER - IRF	23,345	23,345	3,091,138	13	69,086	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,771	13,771	1,529,587	31	690,726	50.00
51.00	05100	RECOVERY ROOM	10,930	10,930	1,911,665	6	15,241	51.00
53.00	05300	ANESTHESIOLOGY	173	173	59,951	3	31,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,971	14,971	1,472,868	35	21,775	54.00
54.01	03650	VASCULAR LAB	1,944	1,944	435,617	1	13,029	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	33,537	33,537	763,501	31	14,052	55.00
57.00	05700	CT SCAN	2,256	2,256	399,678	0	11,191	57.00
58.00	05800	MRI	2,368	2,368	155,913	0	6	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,336	3,336	1,101,869	0	125,645	59.00
60.00	06000	LABORATORY	7,611	7,611	0	20	52,957	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,362	2,362	925,676	7	7,924	65.00
66.00	06600	PHYSICAL THERAPY	6,055	6,055	3,330,255	11	11,927	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,502	6,502	474,971	7	5,598	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	278	278	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,920	2,920	336,461	17	142	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	186,325	0	1,108	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	60,845	0	5,383	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	16,894	16,894	2,776,939	37	49,114	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	546,811	546,811	38,263,577	540	1,837,503	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	1,026	194.00
194.01	07951	MOB	0	0	0	29	0	194.01
194.02	07952	COMMUNITY WELLNESS	570	570	71,732	0	687	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	4	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHO NES)	PURCHASING RECEIVING AND STORES (PURCH REQU IS \$)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,919,375	7,279,172	6,632,924	108,565	2,101	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.506470	13.298182	0.173024	188.808696	0.001142	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	3,008	47	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	5.231304	0.000026	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: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN 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	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	796,928,361					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	796,928,361				5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	-29,858,071	101,329,456		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	2,099,558	357,379	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	8,162,305	106,288	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	342,807	1,428	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,022,212	11,521	9.00
10.00	01000	DIETARY	0	0	0	1,699,100	20,274	10.00
11.00	01100	CAFETERIA	0	0	0	1,774,533	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,253,007	1,971	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,009,203	11,913	14.00
15.00	01500	PHARMACY	0	0	0	2,538,431	3,157	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	50,823	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	109,129,432	109,129,432	0	14,905,742	42,715	30.00
31.00	03100	INTENSIVE CARE UNIT	21,390,154	21,390,154	0	3,807,390	8,289	31.00
41.00	04100	SUBPROVIDER - IRF	28,087,331	28,087,331	0	4,412,134	23,345	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,822,332	79,822,332	0	3,538,379	13,771	50.00
51.00	05100	RECOVERY ROOM	37,513,811	37,513,811	0	2,629,577	10,930	51.00
53.00	05300	ANESTHESIOLOGY	15,388,071	15,388,071	0	102,970	173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,944,807	26,944,807	0	2,600,165	14,971	54.00
54.01	03650	VASCULAR LAB	12,078,417	12,078,417	0	637,455	1,944	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	18,540,657	18,540,657	0	2,232,180	33,537	55.00
57.00	05700	CT SCAN	53,598,039	53,598,039	0	736,845	2,256	57.00
58.00	05800	MRI	12,134,319	12,134,319	0	384,519	2,368	58.00
59.00	05900	CARDIAC CATHETERIZATION	47,784,157	47,784,157	0	4,025,878	3,336	59.00
60.00	06000	LABORATORY	61,078,883	61,078,883	0	5,394,112	7,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,673,806	1,673,806	0	325,098	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,971,697	7,971,697	0	1,263,164	2,362	65.00
66.00	06600	PHYSICAL THERAPY	37,049,103	37,049,103	0	5,474,590	6,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,968,661	20,968,661	0	758,320	6,502	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,125,463	29,125,463	0	3,915,961	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,108,460	51,108,460	0	7,389,311	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,727,764	47,727,764	0	7,264,079	0	73.00
74.00	07400	RENAL DIALYSIS	2,750,304	2,750,304	0	568,454	278	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,894,868	4,894,868	0	476,441	2,920	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,573,208	1,573,208	0	298,967	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,858,235	5,858,235	0	703,141	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	62,736,382	62,736,382	0	4,148,082	16,894	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	796,928,361	796,928,361	-29,858,071	100,944,933	356,809	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	378	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	92,674	0	194.00
194.01	07951	MOB	0	0	0	187,629	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	103,087	570	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	755	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		ADMITTING (GROSS CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	600,877	3,965		29,858,071	2,718,220	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000754	0.000005		0.294663	7.605987	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	49,742	110		3,112,238	92,974	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000062	0.000000		0.030714	0.260155	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: 14-0217

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			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	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	251,091					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,428	30,744				8.00
9.00	00900	HOUSEKEEPING	11,521	0	238,142			9.00
10.00	01000	DIETARY	20,274	0	20,274	30,744		10.00
11.00	01100	CAFETERIA	0	0	0	0	916,254	11.00
13.00	01300	NURSING ADMINISTRATION	1,971	0	1,971	0	47,026	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,913	0	11,913	0	13,414	14.00
15.00	01500	PHARMACY	3,157	0	3,157	0	32,268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,715	21,085	42,715	21,085	290,669	30.00
31.00	03100	INTENSIVE CARE UNIT	8,289	2,170	8,289	2,170	48,001	31.00
41.00	04100	SUBPROVIDER - IRF	23,345	7,489	23,345	7,489	83,198	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,771	0	13,771	0	39,022	50.00
51.00	05100	RECOVERY ROOM	10,930	0	10,930	0	48,643	51.00
53.00	05300	ANESTHESIOLOGY	173	0	173	0	1,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,971	0	14,971	0	39,305	54.00
54.01	03650	VASCULAR LAB	1,944	0	1,944	0	9,145	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	33,537	0	33,537	0	19,776	55.00
57.00	05700	CT SCAN	2,256	0	2,256	0	11,377	57.00
58.00	05800	MRI	2,368	0	2,368	0	3,756	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,336	0	3,336	0	21,493	59.00
60.00	06000	LABORATORY	7,611	0	7,611	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,362	0	2,362	0	24,071	65.00
66.00	06600	PHYSICAL THERAPY	6,055	0	6,055	0	82,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,502	0	6,502	0	13,821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	278	0	278	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,920	0	2,920	0	10,301	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	4,864	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	1,654	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	16,894	0	16,894	0	69,168	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,521	30,744	237,572	30,744	914,603	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	570	0	570	0	1,651	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	11,375,861	519,378	3,227,679	3,547,279	2,297,422	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	45.305730	16.893638	13.553590	115.381180	2.507407	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,064,588	46,645	353,454	595,018	54,513	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	8.222469	1.517207	1.484215	19.353955	0.059496	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: 14-0217

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	PARAMED ED PRGM-AMBULANCE (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN 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
13.00	01300	NURSING ADMINISTRATION	440,542					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,244,375				14.00
15.00	01500	PHARMACY	0	0	7,227,853			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	796,928,361		16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	197,482	0	0	109,129,432	0	30.00
31.00	03100	INTENSIVE CARE UNIT	47,381	0	0	21,390,154	0	31.00
41.00	04100	SUBPROVIDER - IRF	55,824	0	0	28,087,331	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,700	0	0	79,822,332	0	50.00
51.00	05100	RECOVERY ROOM	38,728	0	0	37,513,811	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,388,071	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,172	0	0	26,944,807	0	54.00
54.01	03650	VASCULAR LAB	2,478	0	0	12,078,417	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	10,083	0	0	18,540,657	0	55.00
57.00	05700	CT SCAN	95	0	0	53,598,039	0	57.00
58.00	05800	MRI	59	0	0	12,134,319	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,461	0	0	47,784,157	0	59.00
60.00	06000	LABORATORY	0	0	0	61,078,883	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,673,806	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,971,697	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	37,049,103	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,287	0	0	20,968,661	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,893,856	0	29,125,463	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,350,519	0	51,108,460	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,227,853	47,727,764	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,750,304	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,947	0	0	4,894,868	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	2,419	0	0	1,573,208	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,654	0	0	5,858,235	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	46,614	0	0	62,736,382	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	440,384	11,244,375	7,227,853	796,928,361	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	158	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	PARAMED ED PRGM-AMBULANCE (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4,460,464	2,132,013	3,577,153	65,799	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.124946	0.189607	0.494912	0.000083	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	155,587	350,752	164,440	1,666	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.353172	0.031194	0.022751	0.000002	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

			Title XVIII		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,663,056		27,663,056	18,716	27,681,772
31.00	03100	INTENSIVE CARE UNIT	6,369,117		6,369,117	8,851	6,377,968
41.00	04100	SUBPROVIDER - IRF	9,030,623		9,030,623	0	9,030,623
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,769,857		5,769,857	0	5,769,857
51.00	05100	RECOVERY ROOM	4,648,083		4,648,083	0	4,648,083
53.00	05300	ANESTHESIOLOGY	149,818		149,818	0	149,818
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,514,545		4,514,545	11,420	4,525,965
54.01	03650	VASCULAR LAB	1,003,520		1,003,520	0	1,003,520
55.00	05500	RADIOLOGY-THERAPEUTIC	5,272,183		5,272,183	35,425	5,307,608
57.00	05700	CT SCAN	1,137,850		1,137,850	0	1,137,850
58.00	05800	MRI	666,235		666,235	0	666,235
59.00	05900	CARDIAC CATHETERIZATION	5,597,659		5,597,659	25,544	5,623,203
60.00	06000	LABORATORY	7,494,494		7,494,494	0	7,494,494
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	421,031		421,031	0	421,031
65.00	06500	RESPIRATORY THERAPY	1,853,381	0	1,853,381	0	1,853,381
66.00	06600	PHYSICAL THERAPY	7,699,237	0	7,699,237	0	7,699,237
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,483,602		1,483,602	0	1,483,602
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,810,569		5,810,569	0	5,810,569
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,964,621		10,964,621	0	10,964,621
73.00	07300	DRUGS CHARGED TO PATIENTS	12,985,648		12,985,648	0	12,985,648
74.00	07400	RENAL DIALYSIS	754,661		754,661	0	754,661
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0		0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	856,857		856,857	0	856,857
76.03	03951	OCCUPATIONAL HEALTH	0		0	0	0
76.97	07697	CARDIAC REHABILITATION	423,881		423,881	0	423,881
76.98	07698	HYPERBARIC OXYGEN THERAPY	931,711		931,711	0	931,711
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0		0	0	0
91.00	09100	EMERGENCY	7,143,836		7,143,836	14,219	7,158,055
91.01	09101	C'VILLE OUT	0		0	0	0
91.02	09102	LAKE HILL OUT	0		0	0	0
91.03	09103	NUTRITION COUNSELING	0		0	0	0
91.04	09104	HUNTLEY OP	0		0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,096,869		3,096,869		3,096,869
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	133,742,944	0	133,742,944	114,175	133,857,119
201.00		Less Observation Beds	3,096,869		3,096,869		3,096,869
202.00		Total (see instructions)	130,646,075	0	130,646,075	114,175	130,760,250

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 11:32 pm	
					Title XVIII		Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,859,000		93,859,000			30.00
31.00	03100	INTENSIVE CARE UNIT	21,390,154		21,390,154			31.00
41.00	04100	SUBPROVIDER - IRF	28,087,331		28,087,331			41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,253,084	58,569,248	79,822,332	0.072284	0.000000	50.00
51.00	05100	RECOVERY ROOM	10,249,181	27,264,630	37,513,811	0.123903	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,245,933	11,142,138	15,388,071	0.009736	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,368,044	20,576,763	26,944,807	0.167548	0.000000	54.00
54.01	03650	VASCULAR LAB	3,487,788	8,590,629	12,078,417	0.083084	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	473,259	18,067,398	18,540,657	0.284358	0.000000	55.00
57.00	05700	CT SCAN	14,537,561	39,060,478	53,598,039	0.021229	0.000000	57.00
58.00	05800	MRI	2,697,916	9,436,403	12,134,319	0.054905	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,872,414	32,911,743	47,784,157	0.117145	0.000000	59.00
60.00	06000	LABORATORY	30,838,852	30,240,031	61,078,883	0.122702	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,028,910	644,896	1,673,806	0.251541	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,088,661	883,036	7,971,697	0.232495	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	25,495,814	11,553,289	37,049,103	0.207812	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,594,487	13,374,174	20,968,661	0.070753	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,530,195	21,595,268	29,125,463	0.199501	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,369,570	38,738,890	51,108,460	0.214536	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,344,715	28,383,049	47,727,764	0.272077	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,620,554	129,750	2,750,304	0.274392	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0.000000	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,666,353	1,228,515	4,894,868	0.175052	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,573,208	1,573,208	0.269437	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9,423	5,848,812	5,858,235	0.159043	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	23,036,323	39,700,059	62,736,382	0.113871	0.000000	91.00
91.01	09101	C'VILLE OUT	0	0	0	0.000000	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0.000000	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,327,337	8,943,095	15,270,432	0.202802	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	368,472,859	428,455,502	796,928,361			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	368,472,859	428,455,502	796,928,361			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.072284		50.00
51.00	05100	RECOVERY ROOM	0.123903		51.00
53.00	05300	ANESTHESIOLOGY	0.009736		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167972		54.00
54.01	03650	VASCULAR LAB	0.083084		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.286269		55.00
57.00	05700	CT SCAN	0.021229		57.00
58.00	05800	MRI	0.054905		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117679		59.00
60.00	06000	LABORATORY	0.122702		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.251541		62.00
65.00	06500	RESPIRATORY THERAPY	0.232495		65.00
66.00	06600	PHYSICAL THERAPY	0.207812		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.070753		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.199501		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214536		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272077		73.00
74.00	07400	RENAL DIALYSIS	0.274392		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.175052		76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	0.269437		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.159043		76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000		90.01
91.00	09100	EMERGENCY	0.114097		91.00
91.01	09101	C'VILLE OUT	0.000000		91.01
91.02	09102	LAKE HILL OUT	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	0.000000		91.03
91.04	09104	HUNTLEY OP	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.202802		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	27,663,056		27,663,056	18,716	27,681,772	30.00	
31.00	03100	INTENSIVE CARE UNIT	6,369,117		6,369,117	8,851	6,377,968	31.00	
41.00	04100	SUBPROVIDER - IRF	9,030,623		9,030,623	0	9,030,623	41.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	5,769,857		5,769,857	0	5,769,857	50.00	
51.00	05100	RECOVERY ROOM	4,648,083		4,648,083	0	4,648,083	51.00	
53.00	05300	ANESTHESIOLOGY	149,818		149,818	0	149,818	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,514,545		4,514,545	11,420	4,525,965	54.00	
54.01	03650	VASCULAR LAB	1,003,520		1,003,520	0	1,003,520	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	5,272,183		5,272,183	35,425	5,307,608	55.00	
57.00	05700	CT SCAN	1,137,850		1,137,850	0	1,137,850	57.00	
58.00	05800	MRI	666,235		666,235	0	666,235	58.00	
59.00	05900	CARDIAC CATHETERIZATION	5,597,659		5,597,659	25,544	5,623,203	59.00	
60.00	06000	LABORATORY	7,494,494		7,494,494	0	7,494,494	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	421,031		421,031	0	421,031	62.00	
65.00	06500	RESPIRATORY THERAPY	1,853,381	0	1,853,381	0	1,853,381	65.00	
66.00	06600	PHYSICAL THERAPY	7,699,237	0	7,699,237	0	7,699,237	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,483,602		1,483,602	0	1,483,602	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,810,569		5,810,569	0	5,810,569	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,964,621		10,964,621	0	10,964,621	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	12,985,648		12,985,648	0	12,985,648	73.00	
74.00	07400	RENAL DIALYSIS	754,661		754,661	0	754,661	74.00	
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0		0	0	0	76.00	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	856,857		856,857	0	856,857	76.02	
76.03	03951	OCCUPATIONAL HEALTH	0		0	0	0	76.03	
76.97	07697	CARDIAC REHABILITATION	423,881		423,881	0	423,881	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	931,711		931,711	0	931,711	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0		0	0	0	90.01	
91.00	09100	EMERGENCY	7,143,836		7,143,836	14,219	7,158,055	91.00	
91.01	09101	C'VILLE OUT	0		0	0	0	91.01	
91.02	09102	LAKE HILL OUT	0		0	0	0	91.02	
91.03	09103	NUTRITION COUNSELING	0		0	0	0	91.03	
91.04	09104	HUNTLEY OP	0		0	0	0	91.04	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,096,869		3,096,869		3,096,869	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	133,742,944	0	133,742,944	114,175	133,857,119	200.00	
201.00		Less Observation Beds	3,096,869		3,096,869		3,096,869	201.00	
202.00		Total (see instructions)	130,646,075	0	130,646,075	114,175	130,760,250	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 11:32 pm	
					Title XIX		Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,859,000		93,859,000			30.00
31.00	03100	INTENSIVE CARE UNIT	21,390,154		21,390,154			31.00
41.00	04100	SUBPROVIDER - IRF	28,087,331		28,087,331			41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,253,084	58,569,248	79,822,332	0.072284	0.000000	50.00
51.00	05100	RECOVERY ROOM	10,249,181	27,264,630	37,513,811	0.123903	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,245,933	11,142,138	15,388,071	0.009736	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,368,044	20,576,763	26,944,807	0.167548	0.000000	54.00
54.01	03650	VASCULAR LAB	3,487,788	8,590,629	12,078,417	0.083084	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	473,259	18,067,398	18,540,657	0.284358	0.000000	55.00
57.00	05700	CT SCAN	14,537,561	39,060,478	53,598,039	0.021229	0.000000	57.00
58.00	05800	MRI	2,697,916	9,436,403	12,134,319	0.054905	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,872,414	32,911,743	47,784,157	0.117145	0.000000	59.00
60.00	06000	LABORATORY	30,838,852	30,240,031	61,078,883	0.122702	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,028,910	644,896	1,673,806	0.251541	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,088,661	883,036	7,971,697	0.232495	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	25,495,814	11,553,289	37,049,103	0.207812	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,594,487	13,374,174	20,968,661	0.070753	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,530,195	21,595,268	29,125,463	0.199501	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,369,570	38,738,890	51,108,460	0.214536	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,344,715	28,383,049	47,727,764	0.272077	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,620,554	129,750	2,750,304	0.274392	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0.000000	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,666,353	1,228,515	4,894,868	0.175052	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,573,208	1,573,208	0.269437	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9,423	5,848,812	5,858,235	0.159043	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	23,036,323	39,700,059	62,736,382	0.113871	0.000000	91.00
91.01	09101	C'VILLE OUT	0	0	0	0.000000	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0.000000	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,327,337	8,943,095	15,270,432	0.202802	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	368,472,859	428,455,502	796,928,361			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	368,472,859	428,455,502	796,928,361			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.072284			50.00
51.00	05100	RECOVERY ROOM	0.123903			51.00
53.00	05300	ANESTHESIOLOGY	0.009736			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167972			54.00
54.01	03650	VASCULAR LAB	0.083084			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.286269			55.00
57.00	05700	CT SCAN	0.021229			57.00
58.00	05800	MRI	0.054905			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117679			59.00
60.00	06000	LABORATORY	0.122702			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.251541			62.00
65.00	06500	RESPIRATORY THERAPY	0.232495			65.00
66.00	06600	PHYSICAL THERAPY	0.207812			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.070753			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.199501			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214536			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272077			73.00
74.00	07400	RENAL DIALYSIS	0.274392			74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000			76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.175052			76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000			76.03
76.97	07697	CARDIAC REHABILITATION	0.269437			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.159043			76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0.000000			90.01
91.00	09100	EMERGENCY	0.114097			91.00
91.01	09101	C'VILLE OUT	0.000000			91.01
91.02	09102	LAKE HILL OUT	0.000000			91.02
91.03	09103	NUTRITION COUNSELING	0.000000			91.03
91.04	09104	HUNTLEY OP	0.000000			91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.202802			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,769,857	490,860	5,278,997	0	0 50.00
51.00	05100	RECOVERY ROOM	4,648,083	392,381	4,255,702	0	0 51.00
53.00	05300	ANESTHESIOLOGY	149,818	8,886	140,932	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,514,545	486,731	4,027,814	0	0 54.00
54.01	03650	VASCULAR LAB	1,003,520	73,820	929,700	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,272,183	972,481	4,299,702	0	0 55.00
57.00	05700	CT SCAN	1,137,850	87,169	1,050,681	0	0 57.00
58.00	05800	MRI	666,235	76,225	590,010	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	5,597,659	220,997	5,376,662	0	0 59.00
60.00	06000	LABORATORY	7,494,494	373,447	7,121,047	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	421,031	10,097	410,934	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	1,853,381	104,009	1,749,372	0	0 65.00
66.00	06600	PHYSICAL THERAPY	7,699,237	337,564	7,361,673	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,483,602	200,721	1,282,881	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,810,569	243,604	5,566,965	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,964,621	459,513	10,505,108	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,985,648	390,603	12,595,045	0	0 73.00
74.00	07400	RENAL DIALYSIS	754,661	25,079	729,582	0	0 74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0 76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	856,857	94,510	762,347	0	0 76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	423,881	10,426	413,455	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	931,711	22,653	909,058	0	0 76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	7,143,836	604,468	6,539,368	0	0 91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0 91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0 91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0 91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0 91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,096,869	239,010	2,857,859	0	0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	90,680,148	5,925,254	84,754,894	0	0 200.00
201.00		Less Observation Beds	3,096,869	239,010	2,857,859	0	0 201.00
202.00		Total (line 200 minus line 201)	87,583,279	5,686,244	81,897,035	0	0 202.00

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

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description				Title XIX		Hospital	PPS
				Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
				6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		5,769,857	79,822,332	0.072284	50.00
51.00	05100	RECOVERY ROOM		4,648,083	37,513,811	0.123903	51.00
53.00	05300	ANESTHESIOLOGY		149,818	15,388,071	0.009736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,514,545	26,944,807	0.167548	54.00
54.01	03650	VASCULAR LAB		1,003,520	12,078,417	0.083084	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		5,272,183	18,540,657	0.284358	55.00
57.00	05700	CT SCAN		1,137,850	53,598,039	0.021229	57.00
58.00	05800	MRI		666,235	12,134,319	0.054905	58.00
59.00	05900	CARDIAC CATHETERIZATION		5,597,659	47,784,157	0.117145	59.00
60.00	06000	LABORATORY		7,494,494	61,078,883	0.122702	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		421,031	1,673,806	0.251541	62.00
65.00	06500	RESPIRATORY THERAPY		1,853,381	7,971,697	0.232495	65.00
66.00	06600	PHYSICAL THERAPY		7,699,237	37,049,103	0.207812	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		1,483,602	20,968,661	0.070753	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		5,810,569	29,125,463	0.199501	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		10,964,621	51,108,460	0.214536	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		12,985,648	47,727,764	0.272077	73.00
74.00	07400	RENAL DIALYSIS		754,661	2,750,304	0.274392	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		856,857	4,894,868	0.175052	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		423,881	1,573,208	0.269437	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		931,711	5,858,235	0.159043	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES		0	0	0.000000	90.01
91.00	09100	EMERGENCY		7,143,836	62,736,382	0.113871	91.00
91.01	09101	C'VILLE OUT		0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT		0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0.000000	91.03
91.04	09104	HUNTLEY OP		0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		3,096,869	15,270,432	0.202802	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)		90,680,148	653,591,876		200.00
201.00		Less Observation Beds		3,096,869	0		201.00
202.00		Total (line 200 minus line 201)		87,583,279	653,591,876		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,136,427	0	2,136,427	23,741	89.99	30.00
31.00	INTENSIVE CARE UNIT	405,138		405,138	2,170	186.70	31.00
41.00	SUBPROVIDER - IRF	943,331	0	943,331	7,489	125.96	41.00
200.00	Total (lines 30 through 199)	3,484,896		3,484,896	33,400		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	6,627	596,364				30.00
31.00	INTENSIVE CARE UNIT	726	135,544				31.00
41.00	SUBPROVIDER - IRF	5,163	650,331				41.00
200.00	Total (lines 30 through 199)	12,516	1,382,239				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

			Title XVIII		Hospital	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	490,860	79,822,332	0.006149	8,672,496	53,327	50.00
51.00	05100	RECOVERY ROOM	392,381	37,513,811	0.010460	3,902,075	40,816	51.00
53.00	05300	ANESTHESIOLOGY	8,886	15,388,071	0.000577	1,564,579	903	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,731	26,944,807	0.018064	2,669,651	48,225	54.00
54.01	03650	VASCULAR LAB	73,820	12,078,417	0.006112	1,141,847	6,979	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	972,481	18,540,657	0.052451	326,818	17,142	55.00
57.00	05700	CT SCAN	87,169	53,598,039	0.001626	5,920,310	9,626	57.00
58.00	05800	MRI	76,225	12,134,319	0.006282	1,122,906	7,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	220,997	47,784,157	0.004625	5,467,092	25,285	59.00
60.00	06000	LABORATORY	373,447	61,078,883	0.006114	10,702,494	65,435	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,097	1,673,806	0.006032	408,518	2,464	62.00
65.00	06500	RESPIRATORY THERAPY	104,009	7,971,697	0.013047	2,472,733	32,262	65.00
66.00	06600	PHYSICAL THERAPY	337,564	37,049,103	0.009111	4,406,725	40,150	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,721	20,968,661	0.009572	3,318,650	31,766	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,604	29,125,463	0.008364	2,649,676	22,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	459,513	51,108,460	0.008991	5,646,977	50,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,603	47,727,764	0.008184	6,326,493	51,776	73.00
74.00	07400	RENAL DIALYSIS	25,079	2,750,304	0.009119	801,887	7,312	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	94,510	4,894,868	0.019308	236,968	4,575	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	10,426	1,573,208	0.006627	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	22,653	5,858,235	0.003867	9,238	36	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	604,468	62,736,382	0.009635	7,783,195	74,991	91.00
91.01	09101	C'VILLE OUT	0	0	0.000000	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0.000000	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	239,010	15,270,432	0.015652	2,087,186	32,669	92.00
200.00		Total (lines 50 through 199)	5,925,254	653,591,876		77,638,514	625,727	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 11:32 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00	
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	23,741	0.00		6,627	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	2,170	0.00		726	31.00	
41.00	04100	SUBPROVIDER - IRF		0	0	7,489	0.00		5,163	41.00	
200.00		Total (lines 30 through 199)			0	33,400			12,516	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	
41.00	04100	SUBPROVIDER - IRF		0						41.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 11:32 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	79,822,332	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,513,811	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,388,071	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,944,807	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	12,078,417	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,540,657	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	53,598,039	0.000000	57.00
58.00	05800	MRI	0	0	0	12,134,319	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	47,784,157	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	61,078,883	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,673,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,971,697	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	37,049,103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,968,661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,125,463	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	51,108,460	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,727,764	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,750,304	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,894,868	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,573,208	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,858,235	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	62,736,382	0.000000	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,270,432	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	653,591,876		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	8,672,496	0	21,789,311	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,902,075	0	9,776,875	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,564,579	0	3,753,180	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,669,651	0	4,721,880	0	54.00
54.01	03650	VASCULAR LAB	0.000000	1,141,847	0	1,921,721	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	326,818	0	5,744,763	0	55.00
57.00	05700	CT SCAN	0.000000	5,920,310	0	8,726,434	0	57.00
58.00	05800	MRI	0.000000	1,122,906	0	3,047,605	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,467,092	0	16,221,722	0	59.00
60.00	06000	LABORATORY	0.000000	10,702,494	0	4,567,152	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	408,518	0	193,148	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,472,733	0	241,610	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,406,725	0	671,385	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,318,650	0	4,010,116	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,649,676	0	9,790,324	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,646,977	0	18,670,538	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,326,493	0	9,439,534	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	801,887	0	42,359	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	236,968	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	688,074	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	9,238	0	2,258,724	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	7,783,195	0	5,944,742	0	91.00
91.01	09101	C'VILLE OUT	0.000000	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,087,186	0	1,938,286	0	92.00
200.00		Total (lines 50 through 199)		77,638,514	0	134,159,483	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 11:32 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.072284	21,789,311	0	0	1,575,019	50.00
51.00	05100	RECOVERY ROOM	0.123903	9,776,875	0	0	1,211,384	51.00
53.00	05300	ANESTHESIOLOGY	0.009736	3,753,180	0	0	36,541	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167548	4,721,880	0	0	791,142	54.00
54.01	03650	VASCULAR LAB	0.083084	1,921,721	0	0	159,664	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284358	5,744,763	0	0	1,633,569	55.00
57.00	05700	CT SCAN	0.021229	8,726,434	0	0	185,253	57.00
58.00	05800	MRI	0.054905	3,047,605	0	0	167,329	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117145	16,221,722	0	0	1,900,294	59.00
60.00	06000	LABORATORY	0.122702	4,567,152	2,699	0	560,399	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.251541	193,148	0	0	48,585	62.00
65.00	06500	RESPIRATORY THERAPY	0.232495	241,610	0	0	56,173	65.00
66.00	06600	PHYSICAL THERAPY	0.207812	671,385	0	0	139,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070753	4,010,116	0	0	283,728	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.199501	9,790,324	0	0	1,953,179	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214536	18,670,538	0	0	4,005,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272077	9,439,534	0	11,343	2,568,280	73.00
74.00	07400	RENAL DIALYSIS	0.274392	42,359	0	0	11,623	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.175052	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.269437	688,074	0	0	185,393	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.159043	2,258,724	0	0	359,234	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.113871	5,944,742	1	0	676,934	91.00
91.01	09101	C'VILLE OUT	0.000000	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.202802	1,938,286	0	0	393,088	92.00
200.00		Subtotal (see instructions)		134,159,483	2,700	11,343	18,901,836	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		134,159,483	2,700	11,343	18,901,836	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/29/2021 11:32 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03650	VASCULAR LAB	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	331	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,086		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	C'VILLE OUT	0	0		91.01
91.02	09102	LAKE HILL OUT	0	0		91.02
91.03	09103	NUTRITION COUNSELING	0	0		91.03
91.04	09104	HUNTLEY OP	0	0		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	331	3,086		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	331	3,086		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 11:32 pm		
				Component CCN: 14-T217				
				Title XVIII		Subprovider - IRF	PPS	
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	490,860	79,822,332	0.006149	109,922	676	50.00
51.00	05100	RECOVERY ROOM	392,381	37,513,811	0.010460	48,974	512	51.00
53.00	05300	ANESTHESIOLOGY	8,886	15,388,071	0.000577	13,222	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,731	26,944,807	0.018064	206,674	3,733	54.00
54.01	03650	VASCULAR LAB	73,820	12,078,417	0.006112	139,430	852	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	972,481	18,540,657	0.052451	4,287	225	55.00
57.00	05700	CT SCAN	87,169	53,598,039	0.001626	247,524	402	57.00
58.00	05800	MRI	76,225	12,134,319	0.006282	69,215	435	58.00
59.00	05900	CARDIAC CATHETERIZATION	220,997	47,784,157	0.004625	14,165	66	59.00
60.00	06000	LABORATORY	373,447	61,078,883	0.006114	1,811,327	11,074	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,097	1,673,806	0.006032	18,622	112	62.00
65.00	06500	RESPIRATORY THERAPY	104,009	7,971,697	0.013047	796,755	10,395	65.00
66.00	06600	PHYSICAL THERAPY	337,564	37,049,103	0.009111	11,592,579	105,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,721	20,968,661	0.009572	120,942	1,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,604	29,125,463	0.008364	131,289	1,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	459,513	51,108,460	0.008991	45,564	410	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,603	47,727,764	0.008184	1,395,818	11,423	73.00
74.00	07400	RENAL DIALYSIS	25,079	2,750,304	0.009119	382,181	3,485	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	94,510	4,894,868	0.019308	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	10,426	1,573,208	0.006627	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	22,653	5,858,235	0.003867	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	604,468	62,736,382	0.009635	5,124	49	91.00
91.01	09101	C'VILLE OUT	0	0	0.000000	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0.000000	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	15,270,432	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,686,244	653,591,876		17,153,614	151,733	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 11:32 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT		0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT		0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP		0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 11:32 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	79,822,332	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	37,513,811	0.000000	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	15,388,071	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	26,944,807	0.000000	54.00
54.01	03650	VASCULAR LAB		0	0	0	12,078,417	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	18,540,657	0.000000	55.00
57.00	05700	CT SCAN		0	0	0	53,598,039	0.000000	57.00
58.00	05800	MRI		0	0	0	12,134,319	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	47,784,157	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	61,078,883	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	1,673,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	7,971,697	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	37,049,103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	20,968,661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	29,125,463	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	51,108,460	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	47,727,764	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	2,750,304	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	4,894,868	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	1,573,208	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	5,858,235	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY		0	0	0	62,736,382	0.000000	91.00
91.01	09101	C'VILLE OUT		0	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT		0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP		0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	15,270,432	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	653,591,876		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 11:32 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	109,922		0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	48,974		0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	13,222		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	206,674		0	0	54.00
54.01	03650	VASCULAR LAB		0.000000	139,430		0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	4,287		0	0	55.00
57.00	05700	CT SCAN		0.000000	247,524		0	0	57.00
58.00	05800	MRI		0.000000	69,215		0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	14,165		0	0	59.00
60.00	06000	LABORATORY		0.000000	1,811,327		0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	18,622		0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0.000000	796,755		0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	11,592,579		0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	120,942		0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	131,289		0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	45,564		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,395,818		0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	382,181		0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0.000000	0		0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.000000	0		0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH		0.000000	0		0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0.000000	0		0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0		0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES		0.000000	0		0	0	90.01
91.00	09100	EMERGENCY		0.000000	5,124		0	3,057	91.00
91.01	09101	C'VILLE OUT		0.000000	0		0	0	91.01
91.02	09102	LAKE HILL OUT		0.000000	0		0	0	91.02
91.03	09103	NUTRITION COUNSELING		0.000000	0		0	0	91.03
91.04	09104	HUNTLEY OP		0.000000	0		0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0		0	0	92.00
200.00		Total (lines 50 through 199)			17,153,614		0	3,057	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:

Worksheet D

Component CCN: 14-T217

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/29/2021 11:32 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.072284	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.123903	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.009736	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.167548	0	0	0	0 54.00
54.01	03650 VASCULAR LAB	0.083084	0	0	0	0 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.284358	0	0	0	0 55.00
57.00	05700 CT SCAN	0.021229	0	0	0	0 57.00
58.00	05800 MRI	0.054905	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117145	0	0	0	0 59.00
60.00	06000 LABORATORY	0.122702	0	0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251541	0	0	0	0 62.00
65.00	06500 RESPIRATORY THERAPY	0.232495	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.207812	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.070753	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.199501	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.214536	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.272077	0	0	4,010	0 73.00
74.00	07400 RENAL DIALYSIS	0.274392	0	0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0 76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.175052	0	0	0	0 76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0 76.03
76.97	07697 CARDIAC REHABILITATION	0.269437	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.159043	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0 90.01
91.00	09100 EMERGENCY	0.113871	3,057	0	0	348 91.00
91.01	09101 C'VILLE OUT	0.000000	0	0	0	0 91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0 91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	0	0 91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0 91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.202802	0	0	0	0 92.00
200.00	Subtotal (see instructions)		3,057	0	4,010	348 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		3,057	0	4,010	348 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0217

Period:

Worksheet D

Component CCN: 14-T217

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/29/2021 11:32 pm

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03650	VASCULAR LAB	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,091		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	C'VILLE OUT	0	0		91.01
91.02	09102	LAKE HILL OUT	0	0		91.02
91.03	09103	NUTRITION COUNSELING	0	0		91.03
91.04	09104	HUNTLEY OP	0	0		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	1,091		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,091		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,136,427	0	2,136,427	23,741	89.99	30.00
31.00	INTENSIVE CARE UNIT	405,138		405,138	2,170	186.70	31.00
41.00	SUBPROVIDER - IRF	943,331	0	943,331	7,489	125.96	41.00
200.00	Total (lines 30 through 199)	3,484,896		3,484,896	33,400		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	1,562	140,564				30.00
31.00	INTENSIVE CARE UNIT	293	54,703				31.00
41.00	SUBPROVIDER - IRF	128	16,123				41.00
200.00	Total (lines 30 through 199)	1,983	211,390				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	490,860	79,822,332	0.006149	0	50.00
51.00	05100	RECOVERY ROOM	392,381	37,513,811	0.010460	0	51.00
53.00	05300	ANESTHESIOLOGY	8,886	15,388,071	0.000577	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,731	26,944,807	0.018064	0	54.00
54.01	03650	VASCULAR LAB	73,820	12,078,417	0.006112	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	972,481	18,540,657	0.052451	0	55.00
57.00	05700	CT SCAN	87,169	53,598,039	0.001626	0	57.00
58.00	05800	MRI	76,225	12,134,319	0.006282	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	220,997	47,784,157	0.004625	0	59.00
60.00	06000	LABORATORY	373,447	61,078,883	0.006114	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,097	1,673,806	0.006032	0	62.00
65.00	06500	RESPIRATORY THERAPY	104,009	7,971,697	0.013047	0	65.00
66.00	06600	PHYSICAL THERAPY	337,564	37,049,103	0.009111	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,721	20,968,661	0.009572	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	243,604	29,125,463	0.008364	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	459,513	51,108,460	0.008991	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,603	47,727,764	0.008184	0	73.00
74.00	07400	RENAL DIALYSIS	25,079	2,750,304	0.009119	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0.000000	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	94,510	4,894,868	0.019308	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	10,426	1,573,208	0.006627	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	22,653	5,858,235	0.003867	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	90.01
91.00	09100	EMERGENCY	604,468	62,736,382	0.009635	0	91.00
91.01	09101	C'VILLE OUT	0	0	0.000000	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0.000000	0	91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	239,010	15,270,432	0.015652	0	92.00
200.00		Total (lines 50 through 199)	5,925,254	653,591,876		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0217		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 11:32 pm		
					Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
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	23,741	0.00	1,562	30.00			
31.00	03100	INTENSIVE CARE UNIT		0	2,170	0.00	293	31.00			
41.00	04100	SUBPROVIDER - IRF	0	0	7,489	0.00	128	41.00			
200.00		Total (lines 30 through 199)		0	33,400		1,983	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
41.00	04100	SUBPROVIDER - IRF	0								41.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			Title XIX		Hospital		PPS	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	79,822,332	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,513,811	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,388,071	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,944,807	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	12,078,417	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	18,540,657	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	53,598,039	0.000000	57.00
58.00	05800	MRI	0	0	0	12,134,319	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	47,784,157	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	61,078,883	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,673,806	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,971,697	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	37,049,103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,968,661	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,125,463	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	51,108,460	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,727,764	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,750,304	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,894,868	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,573,208	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	5,858,235	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	62,736,382	0.000000	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,270,432	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	653,591,876		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0
54.01	03650	VASCULAR LAB	0.000000	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0
57.00	05700	CT SCAN	0.000000	0	0	0	0
58.00	05800	MRI	0.000000	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.000000	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0	0
91.01	09101	C'VILLE OUT	0.000000	0	0	0	0
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	0	0
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		0	0	0	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:32 pm	
Title XVIII		Hospital	PPS		
Cost Center Description		1.00			
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	23,741	1.00		
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,741	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)	21,085	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)	6,627	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)	27,681,772	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)	27,681,772	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)	27,681,772	37.00		
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,165.99	38.00		
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,727,016	39.00		
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00		
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7,727,016	41.00		

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,377,968	2,170	2,939.16	726	2,133,830
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					10,770,286
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					20,631,132
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					731,908
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					625,727
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,357,635
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					19,273,497
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					2,656
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,165.99
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,096,869

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 11:32 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,136,427	27,681,772	0.077178	3,096,869	239,010	90.00
91.00 Nursing School cost	0	27,681,772	0.000000	3,096,869	0	91.00
92.00 Allied health cost	0	27,681,772	0.000000	3,096,869	0	92.00
93.00 All other Medical Education	0	27,681,772	0.000000	3,096,869	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,489	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,489	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)		7,489	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)		5,163	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)		9,030,623	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)		9,030,623	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)		9,030,623	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,205.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,225,804	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)		6,225,804	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:32 pm	
				Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,423,393	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,649,197	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)					650,331	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					151,733	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					802,064	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,847,133	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: 14-0217 Component CCN: 14-T217		Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:32 pm	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	943,331	9,030,623	0.104459	0	0 90.00
91.00	Nursing School cost	0	9,030,623	0.000000	0	0 91.00
92.00	Allied health cost	0	9,030,623	0.000000	0	0 92.00
93.00	All other Medical Education	0	9,030,623	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 11:32 pm	
		Title XIX	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)		23,741	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,741	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)		21,085	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,562	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)		27,681,772	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)		27,681,772	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)		27,681,772	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,165.99	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,821,276	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,821,276	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XIX		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,377,968	2,170	2,939.16	293	861,174
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,682,450
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					195,267
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					195,267
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,487,183
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					2,656
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,165.99
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,096,869

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0217

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

Worksheet D-1

Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,136,427	27,681,772	0.077178	3,096,869	239,010 90.00
91.00	Nursing School cost	0	27,681,772	0.000000	3,096,869	0 91.00
92.00	Allied health cost	0	27,681,772	0.000000	3,096,869	0 92.00
93.00	All other Medical Education	0	27,681,772	0.000000	3,096,869	0 93.00

Health Financial Systems		PRESENCE SAINT JOSEPH HOSPITAL ELGIN		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 11:32 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		31,282,118	30.00
31.00	03100	INTENSIVE CARE UNIT		6,995,629	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.072284	8,672,496	50.00
51.00	05100	RECOVERY ROOM	0.123903	3,902,075	51.00
53.00	05300	ANESTHESIOLOGY	0.009736	1,564,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167972	2,669,651	54.00
54.01	03650	VASCULAR LAB	0.083084	1,141,847	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.286269	326,818	55.00
57.00	05700	CT SCAN	0.021229	5,920,310	57.00
58.00	05800	MRI	0.054905	1,122,906	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117679	5,467,092	59.00
60.00	06000	LABORATORY	0.122702	10,702,494	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.251541	408,518	62.00
65.00	06500	RESPIRATORY THERAPY	0.232495	2,472,733	65.00
66.00	06600	PHYSICAL THERAPY	0.207812	4,406,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070753	3,318,650	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.199501	2,649,676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.214536	5,646,977	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272077	6,326,493	73.00
74.00	07400	RENAL DIALYSIS	0.274392	801,887	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.175052	236,968	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.269437	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.159043	9,238	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	90.01
91.00	09100	EMERGENCY	0.114097	7,783,195	91.00
91.01	09101	C'VILLE OUT	0.000000	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	91.02
91.03	09103	NUTRITION COUNSELING	0.000000	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.202802	2,087,186	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		77,638,514	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)		77,638,514	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 11:32 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		19,717,503		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.072284	109,922	7,946	50.00
51.00	05100 RECOVERY ROOM	0.123903	48,974	6,068	51.00
53.00	05300 ANESTHESIOLOGY	0.009736	13,222	129	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.167972	206,674	34,715	54.00
54.01	03650 VASCULAR LAB	0.083084	139,430	11,584	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.286269	4,287	1,227	55.00
57.00	05700 CT SCAN	0.021229	247,524	5,255	57.00
58.00	05800 MRI	0.054905	69,215	3,800	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117679	14,165	1,667	59.00
60.00	06000 LABORATORY	0.122702	1,811,327	222,253	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251541	18,622	4,684	62.00
65.00	06500 RESPIRATORY THERAPY	0.232495	796,755	185,242	65.00
66.00	06600 PHYSICAL THERAPY	0.207812	11,592,579	2,409,077	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.070753	120,942	8,557	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.199501	131,289	26,192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.214536	45,564	9,775	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.272077	1,395,818	379,770	73.00
74.00	07400 RENAL DIALYSIS	0.274392	382,181	104,867	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.175052	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	0.269437	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.159043	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.114097	5,124	585	91.00
91.01	09101 C'VILLE OUT	0.000000	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.202802	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		17,153,614	3,423,393	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)		17,153,614	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,420,375	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,990,321	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)		30,147	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		180,495	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		136.16	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.08	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.86	31.00
32.00	Sum of lines 30 and 31		31.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.57	33.00
34.00	Disproportionate share adjustment (see instructions)		560,936	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,847,374	2,113,304	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	464,367	1,580,635	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,045,002		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0 41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	17,227,276		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)		17,227,276	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,184,858	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		117,241	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		18,529,375	59.00
60.00	Primary payer payments		3,516	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,525,859	61.00
62.00	Deductibles billed to program beneficiaries		1,386,604	62.00
63.00	Coinsurance billed to program beneficiaries		73,337	63.00
64.00	Allowable bad debts (see instructions)		486,686	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		316,346	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		242,148	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,382,264	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-13,150	70.93
70.94	HRR adjustment amount (see instructions)		-18,029	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,351,085	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		16,344,553	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)		1,006,532	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		310,541	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVB Adjustment for HSP Bonus Payment				
101.00	HVB adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVB adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	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: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 11:32 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,420,375	0	3,420,375		3,420,375	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,990,321	0		10,990,321	10,990,321	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	30,147	0	30,147		30,147	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	180,495	0		180,495	180,495	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1557	0.1557	0.1557	0.1557		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	560,936	0	133,138	427,798	560,936	11.00
11.01	Uncompensated care payments	36.00	2,045,002	0	719,336	207,352	926,688	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,227,276	0	4,302,996	12,924,280	17,227,276	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,227,276	0	4,302,996	12,924,280	17,227,276	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,184,858	0	1,471,879	-287,021	1,184,858	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 11:32 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	117,241	0	0	117,241	117,241	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	5,774,875	12,754,500	18,529,375	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,104,570	0	1,373,297	-268,727	1,104,570	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	6,503	0	6,846	-343	6,503	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	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0668	0.0668	0.0668	0.0668		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,785	0	91,736	-17,951	73,785	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,184,858	0	1,471,879	-287,021	1,184,858	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: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 11:32 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,420,375	3,420,375		3,420,375	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,990,321		10,990,321	10,990,321	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	30,147	30,147		30,147	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	180,495		180,495	180,495	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1557	0.1557	0.1557		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	560,936	133,138	427,798	560,936	11.00
11.01	Uncompensated care payments	36.00	2,045,002	234,918	1,123,838	1,358,756	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,227,276	3,818,578	13,408,698	17,227,276	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	17,227,276	3,818,578	13,408,698	17,227,276	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,184,858	1,471,879	-287,021	1,184,858	16.00
17.00	Special add-on payments for new technologies	54.00	117,241	0	117,241	117,241	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,290,457	13,238,918	18,529,375	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/29/2021 11:32 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,104,570	1,373,297	-268,727	1,104,570	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	6,503	6,846	-343	6,503	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0668	0.0668	0.0668		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	73,785	91,736	-17,951	73,785	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,184,858	1,471,879	-287,021	1,184,858	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	-13,150	-13,091	-59	-13,150	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	-18,029	-1,368	-16,661	-18,029	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: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,417	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,901,836	2.00
3.00	OPPS payments		15,278,746	3.00
4.00	Outlier payment (see instructions)		357,376	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)		3,417	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		14,043	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)		14,043	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)		14,043	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		10,626	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)		3,417	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)		15,636,122	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,274,436	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)		13,365,103	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)		13,365,103	30.00
31.00	Primary payer payments		800	31.00
32.00	Subtotal (line 30 minus line 31)		13,364,303	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)		398,736	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		259,178	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		229,829	36.00
37.00	Subtotal (see instructions)		13,623,481	37.00
38.00	MSP-LCC reconciliation amount from PS&R		112	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)		13,623,369	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		13,555,044	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)		68,325	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: 14-0217 Component CCN: 14-T217	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		1,091	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		348	2.00
3.00	OPPS payments		1,078	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)		1,091	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,010	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)		4,010	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)		4,010	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,919	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)		1,091	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)		1,078	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)		0	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)		2,169	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)		2,169	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,169	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)		2,169	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)		2,169	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		2,173	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)		-4	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16,070,493		13,362,686	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		274,060		192,358	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)		16,344,553		13,555,044	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,006,532		68,325	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		17,351,085		13,623,369	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: 14-0217
 Component CCN: 14-T217

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/29/2021 11:32 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		10,730,868		2,173		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)		10,730,868		2,173		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		127,216		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		4		6.02
7.00	Total Medicare program liability (see instructions)		10,858,084		2,169		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: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/29/2021 11:32 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			10,649,386 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0124 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			202,338 3.00
4.00	Outlier Payments			84,779 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			20.517808 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			10,936,503 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			10,936,503 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			10,936,503 19.00
20.00	Deductibles			60,656 20.00
21.00	Subtotal (line 19 minus line 20)			10,875,847 21.00
22.00	Coinsurance			26,770 22.00
23.00	Subtotal (line 21 minus line 22)			10,849,077 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			13,857 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			9,007 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			10,858,084 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			10,858,084 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			10,730,868 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			127,216 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			84,779 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 11:32 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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.	0.00	0.00	0.00	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.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		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	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	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)			0.00	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)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	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)	12,516	3,481		26.00
27.00	Total Inpatient Days (see instructions)	30,744	30,744		27.00
28.00	Ratio of inpatient days to total inpatient days	0.407104	0.113225		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 11:32 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,750,304	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)			30,280,329	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)			3,516	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			30,276,813	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			18,906,692	42.00
43.00	Primary payer payments (see instructions)			800	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			18,905,892	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			49,182,705	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.615599	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.384401	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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

Provider CCN: 14-0217

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

Worksheet G

Date/Time Prepared:
11/29/2021 11:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,150	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,793,888	0	0	0	4.00
5.00	Other receivable	775,182	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,050,099	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,003,291	0	0	0	9.00
10.00	Due from other funds	6,953,993	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	30,578,603	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,020,000	0	0	0	12.00
13.00	Land improvements	2,163,217	0	0	0	13.00
14.00	Accumulated depreciation	-520,559	0	0	0	14.00
15.00	Buildings	52,341,144	0	0	0	15.00
16.00	Accumulated depreciation	-6,461,223	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	19,167,179	0	0	0	23.00
24.00	Accumulated depreciation	-8,087,211	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	585,701	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	64,208,248	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,109,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,109,798	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	96,896,649	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,293,545	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	53,590,674	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	59,884,219	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,758,989	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,758,989	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	62,643,208	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	34,253,441				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)	34,253,441	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	96,896,649	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0217

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

Worksheet G-1

Date/Time Prepared:
11/29/2021 11:32 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		32,540,931		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-12,068,728				2.00
3.00	Total (sum of line 1 and line 2)		20,472,203		0		3.00
4.00	TRANSFERS RESTRICTED CONTRIBUTIONS	1,192,038		0		0	4.00
5.00	NET ASSET TRANS TO FROM ALPHA	12,589,200		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)		13,781,238		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,253,441		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)		34,253,441		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	TRANSFERS RESTRICTED CONTRIBUTIONS		0				4.00
5.00	NET ASSET TRANS TO FROM ALPHA		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: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	93,859,000		93,859,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	28,087,331		28,087,331	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)	121,946,331		121,946,331	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,390,154		21,390,154	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	21,390,154		21,390,154	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	143,336,485		143,336,485	17.00
18.00	Ancillary services	225,136,376	379,812,347	604,948,723	18.00
19.00	Outpatient services	0	48,643,154	48,643,154	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC MISCELLANEOUS INCOME	0	471,566	471,566	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	368,472,861	428,927,067	797,399,928	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		142,645,495		29.00
30.00	BALANCING AMOUNT	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	BALANCING AMOUNT	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)		142,645,495		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0217

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

Worksheet G-3

Date/Time Prepared:
11/29/2021 11:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	797,399,928	1.00
2.00	Less contractual allowances and discounts on patients' accounts	672,353,913	2.00
3.00	Net patient revenues (line 1 minus line 2)	125,046,015	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	142,645,495	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-17,599,480	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	76,285	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	322,888	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	202,534	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	612,898	24.00
24.50	COVID-19 PHE Funding	4,316,147	24.50
25.00	Total other income (sum of lines 6-24)	5,530,752	25.00
26.00	Total (line 5 plus line 25)	-12,068,728	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)	-12,068,728	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0217	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/29/2021 11:32 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,104,570	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,503	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)		63.71	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.08	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		27.86	8.00
9.00	Sum of lines 7 and 8		31.94	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.68	10.00
11.00	Disproportionate share adjustment (see instructions)		73,785	11.00
12.00	Total prospective capital payments (see instructions)		1,184,858	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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			Extraordinary Capital Related Costs	Capital Related Costs		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				CAP REL COSTS-BLDG & FIXT	CAP REL COSTS-MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	01160	COMMUNICATIONS	0	0	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	0	0	0	0	5.02
5.03	00570	ADMITTING	0	0	0	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	0	0	0	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			Extraordinary Capital Related Costs	Capital Related Costs		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				CAP REL COSTS-BLDG & FIXT	CAP REL COSTS-MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
202.00		Total (sum of lines 118 and 190 through 201)	0	0	0	0	0	202.00
203.00		Total Statistical Basis		547,381	547,381	0	38,335,309	203.00
204.00		Unit Cost Multiplier		0.000000	0.000000	0	0.000000	204.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
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Cost Center Description			COMMUNICATIONS	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN 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	0					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	0				5.02
5.03	00570	ADMITTING	0	0	0			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0		5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	0	0	0	0	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		Total (sum of lines 118 and 190 through 201)	0	0	0	0	0	202.00
203.00		Total Statistical Basis	575	1,839,216	796,928,361	796,928,361	101,329,456	203.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		COMMUNICATIONS	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
		5.01	5.02	5.03	5.04	5.05	
204.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	204.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
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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	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	0				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	0	0	0	0		9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		Total (sum of lines 118 and 190 through 201)	0	0	0	0	0	202.00
203.00		Total Statistical Basis	357,379	251,091	30,744	238,142	30,744	203.00
204.00		Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	204.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN 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	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	PARAMED ED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	C'VILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		Total (sum of lines 118 and 190 through 201)	0	0	0	0	0	202.00
203.00		Total Statistical Basis	916,254	440,542	11,244,375	7,227,853	796,928,361	203.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
204.00 Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	204.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description			PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMIN 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
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
23.00	02300	PARAMED ED PRGM-AMBULANCE	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	54.00
54.01	03650	VASCULAR LAB		0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	55.00
57.00	05700	CT SCAN		0	0	0	57.00
58.00	05800	MRI		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE		0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH		0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES		0	0	0	90.01
91.00	09100	EMERGENCY		0	0	0	91.00
91.01	09101	C'VILLE OUT		0	0	0	91.01
91.02	09102	LAKE HILL OUT		0	0	0	91.02
91.03	09103	NUTRITION COUNSELING		0	0	0	91.03
91.04	09104	HUNTLEY OP		0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER		0	0	0	194.00
194.01	07951	MOB	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

Provider CCN: 14-0217

Period:
From 07/01/2020
To 06/30/2021Worksheet L-1
Part I
Date/Time Prepared:
11/29/2021 11:32 pm

Cost Center Description		PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
202.00	Total (sum of lines 118 and 190 through 201)	0	0	0	0		202.00
203.00	Total Statistical Basis	0					203.00
204.00	Unit Cost Multiplier	0.000000					204.00