

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: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 12:45 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 HOSP-CHICAGO (14-0224) 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) FLAVIO MARIN
 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	276,195	-241,827	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	18,071	-358		0	7.00
200.00	Total	0	294,266	-242,185	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: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:45 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2900 NORTH LAKE SHORE DRIVE			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60657		County: COOK 2.00	
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)
				1.00	2.00	3.00	4.00	5.00	6.00 V 7.00 XVIII 8.00 XIX
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PRESENCE SAINT JOSEPH HOSP-CHICAGO	140224	16974	1	07/01/1966	N P O 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								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			SKILLED CARE	145568	16974		01/28/1987	N P N 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:45 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			4	2,708	0	405	8,538	168	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0		25.00
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38.00
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N		40.00
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.						Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
						1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					Y	63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		65.00
65.01				0.00	0.00	0.000000		65.01
			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	42.14	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.00	17.26	0.000000		67.00
67.01		INTERNAL MEDICINE	1400	0.00	57.75	0.000000		67.01

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			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.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:45 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
				1.00	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					115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	0	0	6,243,654			118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.06			122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:45 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: PRESENCE CARE TRANSFORMATION CORP	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 200 S. WACKER DRIVE	PO Box:				142.00	
143.00	City: CHICAGO	State: IL		Zip Code: 60606		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 12:45 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 12:45 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/13/2020	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: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 12:45 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			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.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		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.	PRSENCE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718	PATRICK.GILLILAND@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/30/2021 12:45 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF 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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 12:45 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	206	85,153	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)		206	85,153	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,935	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		225	92,088	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	26	9,490		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		251			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)		1	365			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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 12:45 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)	9,151	2,625	39,020			1.00
2.00	HMO and other (see instructions)	4,989	8,538				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,151	2,625	39,020			7.00
8.00	INTENSIVE CARE UNIT	1,118	110	2,658			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		282	2,096			13.00
14.00	Total (see instructions)	10,269	3,017	43,774	116.89	775.69	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,850	0	6,600	0.00	25.56	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)			113			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)				116.89	801.25	27.00
28.00	Observation Bed Days		334	1,786			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	268	608			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			1			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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 12:45 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	1,876	625	8,781	1.00
2.00 HMO and other (see instructions)			838	2,020		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,876	625	8,781	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 12:45 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	61,845,992	0	61,845,992	1,627,319.04	38.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		1,069,379	0	1,069,379	11,765.00	90.89
4.01	Physicians - Part A - Teaching		1,621,953	0	1,621,953	28,279.29	57.35
5.00	Physician and Non Physician-Part B		637,250	0	637,250	8,758.00	72.76
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	8,298,861	8,298,861	272,950.90	30.40
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,069,778	0	2,069,778	57,800.03	35.81
10.00	Excluded area salaries (see instructions)		3,442,554	99,992	3,542,546	59,891.00	59.15
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,303,742	0	5,303,742	94,343.00	56.22
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		58,000,902	0	58,000,902	863,717.00	67.15
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,057,915	0	10,057,915		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,251,926	0	1,251,926		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		150,764	0	150,764		
22.01	Physician Part A - Teaching		290,755	0	290,755		
23.00	Physician Part B		100,237	0	100,237		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		1,754,478	0	1,754,478		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 12:45 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	171,654	0	171,654	240.00	715.23	26.00
27.00	Administrative & General	5.00	3,507,145	0	3,507,145	50,749.00	69.11	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	12,000	0	12,000	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		2,713,014	0	2,713,014	106,517.00	25.47	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		3,160,761	0	3,160,761	111,777.00	28.28	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,709,382	0	1,709,382	31,349.00	54.53	38.00
39.00	Central Services and Supply	14.00	254,726	0	254,726	12,677.00	20.09	39.00
40.00	Pharmacy	15.00	2,196,440	-99,992	2,096,448	43,512.00	48.18	40.00
41.00	Medical Records & Medical Records Library	16.00	26,091	0	26,091	743.00	35.12	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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/30/2021 12:45 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)	65,460,564	-8,298,861	57,161,703	1,535,624.85	37.22	1.00
2.00	Excluded area salaries (see instructions)	5,512,332	99,992	5,612,324	117,691.03	47.69	2.00
3.00	Subtotal salaries (line 1 minus line 2)	59,948,232	-8,398,853	51,549,379	1,417,933.82	36.36	3.00
4.00	Subtotal other wages & related costs (see inst.)	63,304,644	0	63,304,644	958,060.00	66.08	4.00
5.00	Subtotal wage-related costs (see inst.)	10,208,679	0	10,208,679	0.00	19.80	5.00
6.00	Total (sum of lines 3 thru 5)	133,461,555	-8,398,853	125,062,702	2,375,993.82	52.64	6.00
7.00	Total overhead cost (see instructions)	13,751,213	-99,992	13,651,221	357,564.00	38.18	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2021 12:45 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		2,454,637	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)		5,338,558	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		68,315	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		33,408	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)		183,236	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		985,880	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		4,446,397	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		51,752	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		43,893	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		13,606,076	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0224

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 11/30/2021 12:45 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	4,711,889	14,654,137	1.00
2.00	Hospital	4,711,889	11,379,083	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	477,527	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	2,797,527	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 12:45 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)		0.205974		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		28,270,883		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?		N		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		139,740,728		6.00
7.00	Medicaid cost (line 1 times line 6)		28,782,957		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)		512,074		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)		512,074		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)	11,936,188	2,300,428	14,236,616	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,458,544	2,300,428	4,758,972	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)	2,458,544	2,300,428	4,758,972	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)		2,171,957		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		697,071		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,072,416		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,099,541		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		601,822		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,360,794		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,872,868		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet A Date/Time Prepared: 11/30/2021 12:45 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
			1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		9,345	9,345	3,845,442	3,854,787
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,900,071	1,900,071
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	171,654	8,806,633	8,978,287	-51	8,978,236
5.01	00540	NONPATIENT TELEPHONES	0	0	0	47,764	47,764
5.02	00550	DATA PROCESSING	0	0	0	0	0
5.03	00560	PURCHASING, RECEIVING & STORES	0	0	0	0	0
5.04	00570	ADMITTING	0	0	0	0	0
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0
5.06	00591	ADMINISTRATION & GENERAL	3,507,145	67,774,312	71,281,457	-2,393,986	68,887,471
6.00	00600	MAINTENANCE & REPAIRS	0	5,152	5,152	-52	5,100
7.00	00700	OPERATION OF PLANT	12,000	5,466,908	5,478,908	-990,888	4,488,020
8.00	00800	LAUNDRY & LINEN SERVICE	0	595,560	595,560	0	595,560
9.00	00900	HOUSEKEEPING	0	3,583,401	3,583,401	-9,242	3,574,159
10.00	01000	DIETARY	0	4,528,599	4,528,599	-2,744,739	1,783,860
11.00	01100	CAFETERIA	0	0	0	2,722,924	2,722,924
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,709,382	13,473,898	15,183,280	-874,753	14,308,527
14.00	01400	CENTRAL SERVICES & SUPPLY	254,726	1,022,254	1,276,980	-478,703	798,277
15.00	01500	PHARMACY	2,196,440	4,411,894	6,608,334	-3,983,551	2,624,783
16.00	01600	MEDICAL RECORDS & LIBRARY	26,091	77,496	103,587	-455	103,132
17.00	01700	SOCIAL SERVICE	0	4,668	4,668	0	4,668
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	8,835,831	8,835,831
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	12,112,804	2,719,397	14,832,201	-9,642,932	5,189,269
23.00	02300	PARAMED ED PRGM-(SPECIFY)	228,952	22,098	251,050	126,125	377,175
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,021,374	6,211,810	23,233,184	-1,219,645	22,013,539
31.00	03100	INTENSIVE CARE UNIT	2,172,161	1,056,928	3,229,089	-452,218	2,776,871
43.00	04300	NURSERY	1,541,293	1,859,598	3,400,891	388,929	3,789,820
44.00	04400	SKILLED NURSING FACILITY	2,069,778	360,889	2,430,667	-120,246	2,310,421
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,682,893	16,937,794	21,620,687	-13,436,790	8,183,897
51.00	05100	RECOVERY ROOM	504,910	109,031	613,941	-10,166	603,775
53.00	05300	ANESTHESIOLOGY	93,130	1,606,319	1,699,449	-359,118	1,340,331
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,850,139	1,296,117	3,146,256	-679,553	2,466,703
55.00	05500	RADIOLOGY-THERAPEUTIC	1,001,033	698,319	1,699,352	-95,985	1,603,367
57.00	05700	CT SCAN	287,071	136,073	423,144	-112,702	310,442
58.00	05800	MRI	271,825	111,726	383,551	-84,534	299,017
59.00	05900	CARDIAC CATHETERIZATION	987,425	1,861,305	2,848,730	-1,757,311	1,091,419
60.00	06000	LABORATORY	0	7,086,719	7,086,719	-73,043	7,013,676
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	456,853	456,853	-456,853	0
65.00	06500	RESPIRATORY THERAPY	1,102,867	675,716	1,778,583	-230,998	1,547,585
66.00	06600	PHYSICAL THERAPY	1,589,131	202,442	1,791,573	-8,626	1,782,947
69.00	06900	ELECTROCARDIOLOGY	282,390	296,222	578,612	-10,790	567,822
70.00	07000	ELECTROENCEPHALOGRAPHY	40,541	5,944	46,485	-1,796	44,689
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,496,762	11,496,762
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,020,898	6,020,898
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,780,379	5,780,379
74.00	07400	RENAL DIALYSIS	0	284,093	284,093	0	284,093
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	107,679	10,439	118,118	-1,849	116,269
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	619,317	116,211	735,528	-2,030	733,498
91.00	09100	EMERGENCY	1,973,840	1,488,028	3,461,868	-352,328	3,109,540
91.01	09101	PARTIAL HOSPITALIZATION	214,399	25,658	240,057	0	240,057
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,632,390	155,395,849	214,028,239	579,192	214,607,431
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	3,213,602	2,441,105	5,654,707	-579,192	5,075,515
194.01	07951	LAKE SHORE GUEST UNIT	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	61,845,992	157,836,954	219,682,946	0	219,682,946

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0224

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

Worksheet A

Date/Time Prepared:
11/30/2021 12:45 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	-2,930,387	924,400	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	15,027,163	16,927,234	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,492,381	4,485,855	4.00
5.01	00540	NONPATIENT TELEPHONES	162,575	210,339	5.01
5.02	00550	DATA PROCESSING	9,816,457	9,816,457	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	-123,412	-123,412	5.03
5.04	00570	ADMITTING	59,015	59,015	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	625,221	625,221	5.05
5.06	00591	ADMINISTRATION & GENERAL	-37,204,453	31,683,018	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	5,100	6.00
7.00	00700	OPERATION OF PLANT	5,101,121	9,589,141	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,974	607,534	8.00
9.00	00900	HOUSEKEEPING	0	3,574,159	9.00
10.00	01000	DIETARY	-9,753	1,774,107	10.00
11.00	01100	CAFETERIA	-596,929	2,125,995	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-1,318,204	12,990,323	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	798,277	14.00
15.00	01500	PHARMACY	30,510	2,655,293	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,945	153,077	16.00
17.00	01700	SOCIAL SERVICE	0	4,668	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	8,835,831	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	5,189,269	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	377,175	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-549,076	21,464,463	30.00
31.00	03100	INTENSIVE CARE UNIT	807,163	3,584,034	31.00
43.00	04300	NURSERY	-1,290,068	2,499,752	43.00
44.00	04400	SKILLED NURSING FACILITY	-36,667	2,273,754	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-357,960	7,825,937	50.00
51.00	05100	RECOVERY ROOM	0	603,775	51.00
53.00	05300	ANESTHESIOLOGY	-1,215,437	124,894	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-405,222	2,061,481	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-298,145	1,305,222	55.00
57.00	05700	CT SCAN	0	310,442	57.00
58.00	05800	MRI	0	299,017	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,091,419	59.00
60.00	06000	LABORATORY	47,266	7,060,942	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,547,585	65.00
66.00	06600	PHYSICAL THERAPY	-6,817	1,776,130	66.00
69.00	06900	ELECTROCARDIOLOGY	-97,097	470,725	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44,689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,496,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,020,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,780,379	73.00
74.00	07400	RENAL DIALYSIS	0	284,093	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	116,269	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,420	731,078	90.00
91.00	09100	EMERGENCY	-788,443	2,321,097	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	240,057	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-19,984,461	194,622,970	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	-1,824,040	3,251,475	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,808,501	197,874,445	200.00

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 12:45 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,780,379		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,416		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
	TOTALS		0	5,791,795		
	B - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,020,898		1.00
2.00	ADMINISTRATION & GENERAL	5.06	0	2,464		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
	TOTALS		0	6,023,362		
	C - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,496,762		1.00
2.00	ADMINISTRATION & GENERAL	5.06	0	81,793		2.00
3.00	HOUSEKEEPING	9.00	0	9		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
	TOTALS		0	11,578,564		
	D - NURSEY					
1.00	NURSERY	43.00	420,144	52,618		1.00
	TOTALS		420,144	52,618		

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 12:45 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	0	2,722,924		1.00
	TOTALS		0	2,722,924		
	F - PHYSICIAN DEPR CHAIRMAN					
1.00	ADULTS & PEDIATRICS	30.00	765,014	40,021		1.00
	TOTALS		765,014	40,021		
	G - SALARY PTO ACCRUAL					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	H - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,845,442		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,900,071		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
	TOTALS		0	5,745,513		
	I - PHONES					
1.00	NONPATIENT TELEPHONES	5.01	0	47,764		1.00
	TOTALS		0	47,764		
	J - PHARMACY RESIDENCY COSTS					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	99,992	26,133		1.00
	TOTALS		99,992	26,133		
	L - INTERNS AND RESIDENTS SALARY					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	8,298,861	536,970		1.00
	TOTALS		8,298,861	536,970		
500.00	Grand Total: Increases		9,584,011	32,565,664		500.00

RECLASSIFICATIONS

Provider CCN: 14-0224

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 12:45 pm

		Decreases					11/30/2021 12:45 pm	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
A - DRUGS								
1.00	ADMINISTRATION & GENERAL	5.06	0	54	0	1.00		
2.00	OPERATION OF PLANT	7.00	0	1,504	0	2.00		
3.00	PHARMACY	15.00	0	3,764,495	0	3.00		
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	39	0	4.00		
5.00	ADULTS & PEDIATRICS	30.00	0	158,508	0	5.00		
6.00	INTENSIVE CARE UNIT	31.00	0	31,971	0	6.00		
7.00	NURSERY	43.00	0	7,679	0	7.00		
8.00	SKILLED NURSING FACILITY	44.00	0	7,470	0	8.00		
9.00	OPERATING ROOM	50.00	0	194,338	0	9.00		
10.00	RECOVERY ROOM	51.00	0	1,300	0	10.00		
11.00	ANESTHESIOLOGY	53.00	0	55,581	0	11.00		
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	472,605	0	12.00		
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,227	0	13.00		
14.00	CT SCAN	57.00	0	51,519	0	14.00		
15.00	MRI	58.00	0	543	0	15.00		
16.00	CARDIAC CATHETERIZATION	59.00	0	45,768	0	16.00		
17.00	LABORATORY	60.00	0	5,556	0	17.00		
18.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	456,853	0	18.00		
19.00	RESPIRATORY THERAPY	65.00	0	1,968	0	19.00		
20.00	PHYSICAL THERAPY	66.00	0	13	0	20.00		
21.00	ELECTROCARDIOLOGY	69.00	0	2,343	0	21.00		
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	9	0	22.00		
23.00	CARDIAC REHABILITATION	76.97	0	552	0	23.00		
24.00	CLINIC	90.00	0	80	0	24.00		
25.00	EMERGENCY	91.00	0	53,886	0	25.00		
26.00	OTHER	194.00	0	473,934	0	26.00		
TOTALS			0	5,791,795				
B - IMPLANTS								
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	71,128	0	1.00		
2.00	ADULTS & PEDIATRICS	30.00	0	13,008	0	2.00		
3.00	INTENSIVE CARE UNIT	31.00	0	864	0	3.00		
4.00	NURSERY	43.00	0	677	0	4.00		
5.00	OPERATING ROOM	50.00	0	5,277,641	0	5.00		
6.00	CARDIAC CATHETERIZATION	59.00	0	660,044	0	6.00		
TOTALS			0	6,023,362				
C - CHARGABLE SUPPLIES								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	51	0	1.00		
2.00	MAINTENANCE & REPAIRS	6.00	0	52	0	2.00		
3.00	OPERATION OF PLANT	7.00	0	9,219	0	3.00		
4.00	DIETARY	10.00	0	2,497	0	4.00		
5.00	NURSING ADMINISTRATION	13.00	0	1,868	0	5.00		
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	418,391	0	6.00		
7.00	PHARMACY	15.00	0	65,134	0	7.00		
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	416	0	8.00		
9.00	I&R SERVICES-OTHER PRGM	22.00	0	2,066	0	9.00		
COSTS APPRV								
10.00	ADULTS & PEDIATRICS	30.00	0	1,283,426	0	10.00		
11.00	INTENSIVE CARE UNIT	31.00	0	389,615	0	11.00		
12.00	NURSERY	43.00	0	47,834	0	12.00		
13.00	SKILLED NURSING FACILITY	44.00	0	109,212	0	13.00		
14.00	OPERATING ROOM	50.00	0	7,185,405	0	14.00		
15.00	RECOVERY ROOM	51.00	0	3,657	0	15.00		
16.00	ANESTHESIOLOGY	53.00	0	293,193	0	16.00		
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	172,122	0	17.00		
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	62,934	0	18.00		
19.00	CT SCAN	57.00	0	61,183	0	19.00		
20.00	MRI	58.00	0	46,768	0	20.00		
21.00	CARDIAC CATHETERIZATION	59.00	0	865,428	0	21.00		
22.00	LABORATORY	60.00	0	1,355	0	22.00		
23.00	RESPIRATORY THERAPY	65.00	0	222,838	0	23.00		
24.00	PHYSICAL THERAPY	66.00	0	4,889	0	24.00		
25.00	ELECTROCARDIOLOGY	69.00	0	4,828	0	25.00		
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	856	0	26.00		
27.00	CARDIAC REHABILITATION	76.97	0	1,170	0	27.00		
28.00	CLINIC	90.00	0	1,950	0	28.00		
29.00	EMERGENCY	91.00	0	232,492	0	29.00		
30.00	OTHER	194.00	0	87,715	0	30.00		
TOTALS			0	11,578,564				
D - NURSEY								
1.00	ADULTS & PEDIATRICS	30.00	420,144	52,618	0	1.00		
TOTALS			420,144	52,618				

RECLASSIFICATIONS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Date/Time Prepared:
11/30/2021 12:45 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	E - CAFETERIA						
1.00	DIETARY	10.00	0	2,722,924	0		1.00
	TOTALS		0	2,722,924			
	F - PHYSICIAN DEPR CHAIRMAN						
1.00	I&R SERVICES-OTHER PRGM	22.00	765,014	40,021	0		1.00
	COSTS APPRV						
	TOTALS		765,014	40,021			
	G - SALARY PTO ACCRUAL						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	H - EQUIP DEPRECIATION						
1.00	ADMINISTRATION & GENERAL	5.06	0	2,430,425	9		1.00
2.00	OPERATION OF PLANT	7.00	0	980,165	9		2.00
3.00	HOUSEKEEPING	9.00	0	9,251	0		3.00
4.00	DIETARY	10.00	0	19,318	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	872,885	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	600	0		6.00
7.00	PHARMACY	15.00	0	27,797	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	96,976	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	29,768	0		9.00
10.00	NURSERY	43.00	0	27,643	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	3,564	0		11.00
12.00	OPERATING ROOM	50.00	0	779,406	0		12.00
13.00	RECOVERY ROOM	51.00	0	5,209	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	10,344	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,826	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	29,824	0		16.00
17.00	MRI	58.00	0	37,223	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	186,071	0		18.00
19.00	LABORATORY	60.00	0	66,132	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	6,192	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	3,724	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	3,619	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	931	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	127	0		24.00
25.00	EMERGENCY	91.00	0	65,950	0		25.00
26.00	OTHER	194.00	0	17,543	0		26.00
	TOTALS		0	5,745,513			
	I - PHONES						
1.00	ADMINISTRATION & GENERAL	5.06	0	47,764	0		1.00
	TOTALS		0	47,764			
	J - PHARMACY RESIDENCY COSTS						
1.00	PHARMACY	15.00	99,992	26,133	0		1.00
	TOTALS		99,992	26,133			
	L - INTERNS AND RESIDENTS SALARY						
1.00	I&R SERVICES-OTHER PRGM	22.00	8,298,861	536,970	0		1.00
	COSTS APPRV						
	TOTALS		8,298,861	536,970			
500.00	Grand Total: Decreases		9,584,011	32,565,664			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	26,070,000	0	0	0	0	1.00	
2.00	Land Improvements	462,328	0	0	0	0	2.00	
3.00	Buildings and Fixtures	74,341,187	700,539	0	700,539	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	7,660,951	391,461	0	391,461	0	5.00	
6.00	Movable Equipment	15,266,887	1,355,852	0	1,355,852	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	123,801,353	2,447,852	0	2,447,852	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	123,801,353	2,447,852	0	2,447,852	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	26,070,000	0					1.00
2.00	Land Improvements	462,328	0					2.00
3.00	Buildings and Fixtures	75,041,726	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	8,052,412	0					5.00
6.00	Movable Equipment	16,622,739	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	126,249,205	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	126,249,205	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	9,345	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)	9,345	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	9,345				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,345				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	110,621,403	0	110,621,403	0.947353	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,147,590	0	6,147,590	0.052647	0	2.00
3.00	Total (sum of lines 1-2)	116,768,993	0	116,768,993	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	5,023,488	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	16,927,234	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	21,950,722	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	-4,099,088	0	0	0	924,400	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	16,927,234	2.00
3.00	Total (sum of lines 1-2)	-4,099,088	0	0	0	17,851,634	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0224

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 12:45 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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-4,099,088	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-5,384,479			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	-12,753,803			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-596,929	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-517	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	1,127,683	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	8,739,375	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0224

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 12:45 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	
34.00	MISC REVENUE	B	-4,675	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
38.00	MISC INCOME	A	-2,420	CLINIC	90.00	0	38.00
39.00	MOONLIGHTERS	A	0	I&R SERVICES-OTHER PRGM	22.00	0	39.00
				COSTS APPRV			
40.00	HOCR INTEREST INCOME	B	-4,502,455	ADMINISTRATION & GENERAL	5.06	0	40.00
42.00	PHYS FEES	A	-1,824,040	OTHER	194.00	0	42.00
43.02	MISC INCOME	B	-9,753	DIETARY	10.00	0	43.02
43.03	MISC INCOME	B	-1,035,499	ADMINISTRATION & GENERAL	5.06	0	43.03
43.04	MISC INCOME	B	-3,147	ADULTS & PEDIATRICS	30.00	0	43.04
43.05	MISC INCOME	B	0	I&R SERVICES-OTHER PRGM	22.00	0	43.05
				COSTS APPRV			
43.10	MISC INCOME	B	-11,400	PHARMACY	15.00	0	43.10
44.00	MISC INCOME	B	-1,447,354	NURSING ADMINISTRATION	13.00	0	44.00
45.00	MISC INCOME		0		0.00	0	45.00
46.00	MISC INCOME		0		0.00	0	46.00
47.00	MISC INCOME	B	0	LABORATORY	60.00	0	47.00
48.00	BENEFITS ON PART B DOCS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,808,501				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: 14-0224

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 12:45 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.06	ADMINISTRATION & GENERAL	INTEREST EXPENSE	-5,965,060	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	391,420	4,883,801	2.00
3.00	5.01	NONPATIENT TELEPHONES	TELECOM	162,575	0	3.00
3.01	5.02	DATA PROCESSING	INFORMATION SERVICES	9,816,457	0	3.01
3.02	5.03	PURCHASING, RECEIVING & STORES	MATERIALS MGMT	-123,412	0	3.02
3.03	5.04	ADMITTING	PATIENT ACCESS	59,015	0	3.03
3.04	5.05	CASHIERING/ACCTS RECEIVABLE	REVENUE CYCLE	625,221	0	3.04
3.05	5.06	ADMINISTRATION & GENERAL	ADMIN AND GENERAL	12,335,655	37,893,244	3.05
3.06	7.00	OPERATION OF PLANT	FACILITIES	5,101,121	0	3.06
3.07	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	11,974	0	3.07
3.08	13.00	NURSING ADMINISTRATION	NURSING ADMIN	129,150	0	3.08
3.09	15.00	PHARMACY	PHARMACY ADMIN	41,910	0	3.09
3.10	16.00	MEDICAL RECORDS & LIBRARY	HIM	50,462	0	3.10
3.11	31.00	INTENSIVE CARE UNIT	TELE ICU	807,163	0	3.11
3.12	30.00	ADULTS & PEDIATRICS	BH INTAKE	203,519	0	3.12
3.13	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL	41,018	0	3.13
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL	6,287,788	0	4.00
4.01	60.00	LABORATORY	ALVERNO	7,010,182	6,962,916	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			36,986,158	49,739,961	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		66.67	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

(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: 14-0224

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 12:45 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	-5,965,060	0		1.00
2.00	-4,492,381	0		2.00
3.00	162,575	0		3.00
3.01	9,816,457	0		3.01
3.02	-123,412	0		3.02
3.03	59,015	0		3.03
3.04	625,221	0		3.04
3.05	-25,557,589	0		3.05
3.06	5,101,121	0		3.06
3.07	11,974	0		3.07
3.08	129,150	0		3.08
3.09	41,910	0		3.09
3.10	50,462	0		3.10
3.11	807,163	0		3.11
3.12	203,519	0		3.12
3.13	41,018	9		3.13
4.00	6,287,788	9		4.00
4.01	47,266	0		4.01
5.00	-12,753,803			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0224

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 12:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,048,395	538,095	510,300	211,500	2,940	1.00
2.00	43.00	NURSERY	1,642,521	1,290,068	352,453	169,700	12,636	2.00
3.00	50.00	OPERATING ROOM	649,960	357,960	292,000	246,400	8,760	3.00
4.00	53.00	ANESTHESIOLOGY	1,230,745	1,210,472	20,273	239,400	133	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	400,547	400,547	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	298,145	298,145	0	0	0	6.00
7.00	60.00	LABORATORY	30,000	0	30,000	260,300	335	7.00
8.00	69.00	ELECTROCARDIOLOGY	178,564	97,097	81,467	211,500	997	8.00
9.00	91.00	EMERGENCY	836,742	767,429	69,313	211,500	475	9.00
10.00	5.06	ADMINISTRATION & GENERAL	143,850	143,850	0	0	0	10.00
11.00	44.00	SKILLED NURSING FACILITY	36,667	36,667	0	0	0	11.00
12.00	66.00	PHYSICAL THERAPY	14,850	0	14,850	211,500	79	12.00
200.00			6,510,986	5,140,330	1,370,656		26,355	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	298,947	14,947	0	0	0	1.00
2.00	43.00	NURSERY	1,030,928	51,546	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,037,723	51,886	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	15,308	765	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	41,923	2,096	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	101,378	5,069	0	0	0	8.00
9.00	91.00	EMERGENCY	48,299	2,415	0	0	0	9.00
10.00	5.06	ADMINISTRATION & GENERAL	0	0	0	0	0	10.00
11.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	11.00
12.00	66.00	PHYSICAL THERAPY	8,033	402	0	0	0	12.00
200.00			2,582,539	129,126	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	298,947	211,353	749,448		1.00
2.00	43.00	NURSERY	0	1,030,928	0	1,290,068		2.00
3.00	50.00	OPERATING ROOM	0	1,037,723	0	357,960		3.00
4.00	53.00	ANESTHESIOLOGY	0	15,308	4,965	1,215,437		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	400,547		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	298,145		6.00
7.00	60.00	LABORATORY	0	41,923	0	0		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	101,378	0	97,097		8.00
9.00	91.00	EMERGENCY	0	48,299	21,014	788,443		9.00
10.00	5.06	ADMINISTRATION & GENERAL	0	0	0	143,850		10.00
11.00	44.00	SKILLED NURSING FACILITY	0	0	0	36,667		11.00
12.00	66.00	PHYSICAL THERAPY	0	8,033	6,817	6,817		12.00
200.00			0	2,582,539	244,149	5,384,479		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	924,400	924,400			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,927,234	16,927,234			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,485,855	0	4,485,855		4.00
5.01	00540	NONPATIENT TELEPHONES	210,339	0	0	210,339	5.01
5.02	00550	DATA PROCESSING	9,816,457	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	-123,412	18,957	347,139	0	5.03
5.04	00570	ADMITTING	59,015	0	0	6,175	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	625,221	0	0	9,649	5.05
5.06	00591	ADMINISTRATION & GENERAL	31,683,018	253,969	4,650,530	255,092	5.06
6.00	00600	MAINTENANCE & REPAIRS	5,100	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	9,589,141	148,917	2,726,908	873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	607,534	0	0	772	8.00
9.00	00900	HOUSEKEEPING	3,574,159	17,053	312,262	0	9.00
10.00	01000	DIETARY	1,774,107	11,165	204,441	0	10.00
11.00	01100	CAFETERIA	2,125,995	16,748	306,676	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	12,990,323	3,115	57,037	124,332	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	798,277	10,286	188,353	18,527	14.00
15.00	01500	PHARMACY	2,655,293	5,588	102,327	152,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,077	5,873	107,548	1,898	16.00
17.00	01700	SOCIAL SERVICE	4,668	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	8,835,831	4,365	79,925	603,618	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,189,269	0	0	221,764	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	377,175	0	0	23,926	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,464,463	194,200	3,556,115	1,263,107	30.00
31.00	03100	INTENSIVE CARE UNIT	3,584,034	10,230	187,320	157,992	31.00
43.00	04300	NURSERY	2,499,752	6,962	127,491	142,665	43.00
44.00	04400	SKILLED NURSING FACILITY	2,273,754	40,260	737,231	150,545	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,825,937	57,462	1,052,225	340,610	50.00
51.00	05100	RECOVERY ROOM	603,775	10,397	190,386	36,725	51.00
53.00	05300	ANESTHESIOLOGY	124,894	0	0	6,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,481	15,194	278,234	134,570	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,305,222	5,891	107,882	72,810	55.00
57.00	05700	CT SCAN	310,442	1,373	25,134	20,880	57.00
58.00	05800	MRI	299,017	2,816	51,573	19,771	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,091,419	9,984	182,828	71,820	59.00
60.00	06000	LABORATORY	7,060,942	18,349	335,999	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,547,585	1,437	26,318	80,217	65.00
66.00	06600	PHYSICAL THERAPY	1,776,130	11,650	213,335	115,585	66.00
69.00	06900	ELECTROCARDIOLOGY	470,725	7,174	131,376	20,540	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,689	0	0	2,949	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,496,762	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,020,898	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,780,379	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	284,093	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	116,269	3,892	71,273	7,832	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	731,078	4,859	88,970	45,046	90.00
91.00	09100	EMERGENCY	2,321,097	24,721	452,684	143,567	91.00
91.01	09101	PARTIAL HOSPITALIZATION	240,057	0	0	15,594	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,622,970	922,887	16,899,520	4,252,114	210,339
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	3,251,475	1,513	27,714	233,741	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	197,874,445	924,400	16,927,234	4,485,855	210,339

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			DATA PROCESSING	PURCHASING, REC EIVING&STORES	ADMITTING	CASHIERING/ACC TS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	9,816,457					5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	246,157				5.03
5.04	00570	ADMITTING	0	0	65,190			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	634,870		5.05
5.06	00591	ADMINISTRATION & GENERAL	9,816,457	1,770	0	0	46,687,080	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	5,100	6.00
7.00	00700	OPERATION OF PLANT	0	93	0	0	12,474,809	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	608,306	8.00
9.00	00900	HOUSEKEEPING	0	25	0	0	3,904,657	9.00
10.00	01000	DIETARY	0	28	0	0	1,991,285	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,451,735	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	101	0	0	13,184,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	920	0	0	1,017,328	14.00
15.00	01500	PHARMACY	0	645	0	0	2,920,197	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7	0	0	275,736	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,563	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	9,523,739	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	112	0	0	5,421,372	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	401,101	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,570	19,216	112,799	26,649,272	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,097	2,492	13,396	3,964,087	31.00
43.00	04300	NURSERY	0	188	2,324	12,491	2,793,417	43.00
44.00	04400	SKILLED NURSING FACILITY	0	543	1,139	6,122	3,211,910	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	29,367	5,451	101,585	9,428,461	50.00
51.00	05100	RECOVERY ROOM	0	39	822	10,961	853,105	51.00
53.00	05300	ANESTHESIOLOGY	0	308	1,160	20,456	153,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,264	975	35,109	2,546,458	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	116	185	15,718	1,507,824	55.00
57.00	05700	CT SCAN	0	58	1,403	18,082	377,372	57.00
58.00	05800	MRI	0	3	470	10,654	384,304	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,033	1,738	18,594	1,378,416	59.00
60.00	06000	LABORATORY	0	110	6,119	61,775	7,494,486	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	338	2,489	2,827	63.00
65.00	06500	RESPIRATORY THERAPY	0	93	1,355	7,674	1,667,381	65.00
66.00	06600	PHYSICAL THERAPY	0	13	1,351	8,434	2,131,901	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25	1,361	18,328	652,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	50	1,025	51,222	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	128,153	3,131	34,315	11,662,361	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,109	2,728	29,012	6,119,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,835	57,963	5,847,177	73.00
74.00	07400	RENAL DIALYSIS	0	0	221	1,220	286,692	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6	0	506	200,357	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3	12	2,084	880,157	90.00
91.00	09100	EMERGENCY	0	712	2,314	33,296	2,983,215	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1	0	782	256,434	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,816,457	245,512	65,190	634,870	194,359,357	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	645	0	0	3,515,088	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	9,816,457	246,157	65,190	634,870	197,874,445	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	46,687,080					5.06
6.00	00600	MAINTENANCE & REPAIRS	1,575	6,675				6.00
7.00	00700	OPERATION OF PLANT	3,852,258	1,526	16,328,593			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	187,847	0	0	796,153		8.00
9.00	00900	HOUSEKEEPING	1,205,770	175	554,057	0	5,664,659	9.00
10.00	01000	DIETARY	614,915	114	362,746	0	130,263	10.00
11.00	01100	CAFETERIA	757,103	172	544,146	0	195,404	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,071,312	32	101,203	0	36,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	314,154	105	334,201	415	120,012	14.00
15.00	01500	PHARMACY	901,766	57	181,562	3,427	65,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,148	60	190,826	0	68,526	16.00
17.00	01700	SOCIAL SERVICE	2,335	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,940,959	45	141,813	0	50,925	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,674,136	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	123,861	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,229,342	1,988	6,309,738	276,056	2,265,836	30.00
31.00	03100	INTENSIVE CARE UNIT	1,224,122	105	332,369	7,217	119,354	31.00
43.00	04300	NURSERY	862,616	71	226,212	58,024	81,233	43.00
44.00	04400	SKILLED NURSING FACILITY	991,847	413	1,308,095	52,234	469,739	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,911,537	589	1,866,999	163,435	670,442	50.00
51.00	05100	RECOVERY ROOM	263,441	107	337,809	8,354	121,308	51.00
53.00	05300	ANESTHESIOLOGY	47,549	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786,354	156	493,680	82,479	177,281	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	465,621	60	191,418	24,310	68,738	55.00
57.00	05700	CT SCAN	116,534	14	44,596	0	16,014	57.00
58.00	05800	MRI	118,674	29	91,508	0	32,861	58.00
59.00	05900	CARDIAC CATHETERIZATION	425,659	102	324,398	23,072	116,492	59.00
60.00	06000	LABORATORY	2,314,320	188	596,175	9	214,087	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	873	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	514,892	15	46,697	0	16,769	65.00
66.00	06600	PHYSICAL THERAPY	658,337	119	378,527	2,095	135,930	66.00
69.00	06900	ELECTROCARDIOLOGY	201,530	74	233,106	8,524	83,709	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,818	0	0	514	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,601,372	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,889,796	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,805,626	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	88,531	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	61,871	40	126,463	0	45,413	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	271,795	50	157,863	7,180	56,689	90.00
91.00	09100	EMERGENCY	921,226	253	803,212	74,346	288,435	91.00
91.01	09101	PARTIAL HOSPITALIZATION	79,188	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,601,610	6,659	16,279,419	791,691	5,647,001	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	1,085,470	16	49,174	4,462	17,658	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	46,687,080	6,675	16,328,593	796,153	5,664,659	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
			10.00	11.00	12.00	13.00	14.00		
	GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.01	00540	NONPATIENT TELEPHONES						5.01	
5.02	00550	DATA PROCESSING						5.02	
5.03	00560	PURCHASING, RECEIVING&STORES						5.03	
5.04	00570	ADMITTING						5.04	
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05	
5.06	00591	ADMINISTRATION & GENERAL						5.06	
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	3,099,323					10.00	
11.00	01100	CAFETERIA	0	3,948,560				11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00	
13.00	01300	NURSING ADMINISTRATION	0	80,459	0	17,473,519		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,514	0	581	1,819,310	14.00	
15.00	01500	PHARMACY	0	111,692	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,922	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	609,339	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	150,933	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	27,763	0	0	0	23.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,653,021	1,287,927	0	9,224,614	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	86,305	125,733	0	1,542,343	0	31.00	
43.00	04300	NURSERY	0	118,579	0	1,275,783	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	359,997	148,371	0	1,056,329	0	44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	279,923	0	2,042,564	0	50.00	
51.00	05100	RECOVERY ROOM	0	64,121	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	11,853	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,507	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	83,555	0	301,430	0	55.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MRI	0	15,697	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	57,501	0	362,162	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	69,834	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	93,966	0	67,157	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	23,385	0	2,163	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,737	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,194,004	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	625,306	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 SERVICE COST CENTER	0	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	5,659	0	71,128	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	102,295	0	249,577	0	90.00	
91.00	09100	EMERGENCY	0	129,150	0	1,228,257	0	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	0	13,401	0	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
	SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,099,323	3,762,816	0	17,424,088	1,819,310	118.00	
	NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	185,744	0	49,431	0	194.00	
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01	
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)	3,099,323	3,948,560	0	17,473,519	1,819,310	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4,183,900					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	622,218				16.00
17.00	01700	SOCIAL SERVICE	0	0	9,898			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	110,480	8,247	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		13,130	535	0		31.00
43.00	04300	NURSERY	0	12,244	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,000	1,116	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	99,575	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	10,744	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	20,052	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,414	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,407	0	0	0	55.00
57.00	05700	CT SCAN	0	17,725	0	0	0	57.00
58.00	05800	MRI	0	10,443	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,226	0	0	0	59.00
60.00	06000	LABORATORY	0	60,553	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,440	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,522	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,267	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,965	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,004	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,636	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,438	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,183,900	56,816	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,195	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		496				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,042	0	0	0	90.00
91.00	09100	EMERGENCY	0	32,637	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	767	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		4,183,900	622,218	9,898	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0			201.00
202.00	TOTAL (sum lines 118 through 201)		4,183,900	622,218	9,898	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	13,266,820					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		7,246,441				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			552,725			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,989,548	5,456,370	0	72,462,439	-15,445,918	30.00
31.00	03100	INTENSIVE CARE UNIT	856,780	467,980	0	8,740,060	-1,324,760	31.00
43.00	04300	NURSERY	0	0	0	5,428,179	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	7,606,051	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,424,262	777,943	0	19,665,730	-2,202,205	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,658,989	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	233,432	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,354	145,485	0	4,646,168	-411,839	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,658,363	0	55.00
57.00	05700	CT SCAN	0	0	0	572,255	0	57.00
58.00	05800	MRI	0	0	0	653,516	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,706,028	0	59.00
60.00	06000	LABORATORY	5,377	2,937	0	10,688,132	-8,314	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	6,140	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,323,110	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,476,299	0	66.00
69.00	06900	ELECTROCARDIOLOGY	105,395	57,567	0	1,386,035	-162,962	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	72,295	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,491,373	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,663,287	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	552,725	12,446,244	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	376,418	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	511,427	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,321	5,091	0	1,742,060	-14,412	90.00
91.00	09100	EMERGENCY	609,783	333,068	0	7,403,582	-942,851	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	349,790	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,266,820	7,246,441	552,725	192,967,402	-20,513,261	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	4,907,043	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	13,266,820	7,246,441	552,725	197,874,445	-20,513,261	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	5.05
5.06	00591	ADMINISTRATION & GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
91.01	09101	PARTIAL HOSPITALIZATION	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	194.00
194.01	07951	LAKESHORE GUEST UNIT	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 12:45 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	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	18,957	347,139	366,096	5.03
5.04	00570	ADMITTING	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	1,400	253,969	4,650,530	4,905,899	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	148,917	2,726,908	2,875,825	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	17,053	312,262	329,315	9.00
10.00	01000	DIETARY	0	11,165	204,441	215,606	10.00
11.00	01100	CAFETERIA	0	16,748	306,676	323,424	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,115	57,037	60,152	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	418,923	10,286	188,353	617,562	14.00
15.00	01500	PHARMACY	0	5,588	102,327	107,915	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,873	107,548	113,421	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,365	79,925	84,290	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	194,200	3,556,115	3,750,315	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,230	187,320	197,550	31.00
43.00	04300	NURSERY	0	6,962	127,491	134,453	43.00
44.00	04400	SKILLED NURSING FACILITY	0	40,260	737,231	777,491	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	57,462	1,052,225	1,109,687	50.00
51.00	05100	RECOVERY ROOM	0	10,397	190,386	200,783	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,194	278,234	293,428	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,891	107,882	113,773	55.00
57.00	05700	CT SCAN	0	1,373	25,134	26,507	57.00
58.00	05800	MRI	0	2,816	51,573	54,389	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,984	182,828	192,812	59.00
60.00	06000	LABORATORY	0	18,349	335,999	354,348	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,437	26,318	27,755	65.00
66.00	06600	PHYSICAL THERAPY	0	11,650	213,335	224,985	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,174	131,376	138,550	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,892	71,273	75,165	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	4,859	88,970	93,829	90.00
91.00	09100	EMERGENCY	0	24,721	452,684	477,405	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	420,323	922,887	16,899,520	18,242,730	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	0	1,513	27,714	29,227	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	420,323	924,400	16,927,234	18,271,957	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, REC EIVING&STORES	ADMITTING	CASHIERING/ACC TS RECEIVABLE	
			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	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	243,844			5.03
5.04	00570	ADMITTING	0		0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	0	0	1,753	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0		0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	92	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	24	0	0	9.00
10.00	01000	DIETARY	0	0	28	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	100	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	912	0	0	14.00
15.00	01500	PHARMACY	0	0	639	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	7	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	111	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	6,509	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,087	0	0	31.00
43.00	04300	NURSERY	0	0	186	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	538	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	29,093	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	38	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	305	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,215	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	115	0	0	55.00
57.00	05700	CT SCAN	0	0	58	0	0	57.00
58.00	05800	MRI	0	0	3	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,014	0	0	59.00
60.00	06000	LABORATORY	0	0	109	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	92	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	12	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	25	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	126,942	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	66,483	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 SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	6	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	2	0	0	90.00
91.00	09100	EMERGENCY	0	0	706	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	1	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	243,205	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	639	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	122,252	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	366,096	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	4,907,652					5.06
6.00	00600	MAINTENANCE & REPAIRS	166	166				6.00
7.00	00700	OPERATION OF PLANT	404,945	38	3,280,900			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,746	0	0	19,746		8.00
9.00	00900	HOUSEKEEPING	126,749	4	111,326	0	567,418	9.00
10.00	01000	DIETARY	64,639	3	72,887	0	13,048	10.00
11.00	01100	CAFETERIA	79,586	4	109,335	0	19,573	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	427,971	1	20,335	0	3,640	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,023	3	67,151	10	12,021	14.00
15.00	01500	PHARMACY	94,793	1	36,481	85	6,531	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,951	1	38,343	0	6,864	16.00
17.00	01700	SOCIAL SERVICE	246	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	309,150	1	28,494	0	5,101	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	175,983	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	13,020	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	865,019	50	1,267,813	6,846	226,965	30.00
31.00	03100	INTENSIVE CARE UNIT	128,678	3	66,783	179	11,955	31.00
43.00	04300	NURSERY	90,677	2	45,453	1,439	8,137	43.00
44.00	04400	SKILLED NURSING FACILITY	104,262	10	262,835	1,296	47,053	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	306,057	15	375,136	4,054	67,157	50.00
51.00	05100	RECOVERY ROOM	27,693	3	67,876	207	12,151	51.00
53.00	05300	ANESTHESIOLOGY	4,998	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,661	4	99,195	2,046	17,758	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	48,945	1	38,462	603	6,885	55.00
57.00	05700	CT SCAN	12,250	0	8,961	0	1,604	57.00
58.00	05800	MRI	12,475	1	18,387	0	3,292	58.00
59.00	05900	CARDIAC CATHETERIZATION	44,745	3	65,181	572	11,669	59.00
60.00	06000	LABORATORY	243,279	5	119,789	0	21,445	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	92	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	54,125	0	9,383	0	1,680	65.00
66.00	06600	PHYSICAL THERAPY	69,204	3	76,057	52	13,616	66.00
69.00	06900	ELECTROCARDIOLOGY	21,185	2	46,838	211	8,385	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,663	0	0	13	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	378,572	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	198,653	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,805	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,306	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6,504	1	25,410	0	4,549	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	28,571	1	31,719	178	5,678	90.00
91.00	09100	EMERGENCY	96,838	6	161,389	1,844	28,892	91.00
91.01	09101	PARTIAL HOSPITALIZATION	8,324	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,793,549	166	3,271,019	19,635	565,649	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	114,103	0	9,881	111	1,769	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,907,652	166	3,280,900	19,746	567,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING & STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	366,211					10.00
11.00	01100	CAFETERIA	0	531,922				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	10,839	0	523,038		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,380	0	17	735,079	14.00
15.00	01500	PHARMACY	0	15,046	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	259	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	82,086	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	20,333	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	3,740	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	313,476	173,502	0	276,122	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,198	16,938	0	46,167	0	31.00
43.00	04300	NURSERY	0	15,974	0	38,188	0	43.00
44.00	04400	SKILLED NURSING FACILITY	42,537	19,987	0	31,619	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	37,709	0	61,140	0	50.00
51.00	05100	RECOVERY ROOM	0	8,638	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,597	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,291	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,256	0	9,023	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	2,115	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,746	0	10,841	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	9,408	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,658	0	2,010	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,150	0	65	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	503	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	482,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	252,649	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 SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	762	0	2,129	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	13,780	0	7,471	0	90.00
91.00	09100	EMERGENCY	0	17,398	0	36,766	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,805	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	366,211	506,900	0	521,558	735,079	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	25,022	0	1,480	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	366,211	531,922	0	523,038	735,079	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	261,491					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	167,846				16.00
17.00	01700	SOCIAL SERVICE	0	0	246			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	30,098	205			30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,534	13			31.00
43.00	04300	NURSERY	0	3,296	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,615	28			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,803	0			50.00
51.00	05100	RECOVERY ROOM	0	2,892	0			51.00
53.00	05300	ANESTHESIOLOGY	0	5,397	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,264	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,147	0			55.00
57.00	05700	CT SCAN	0	4,771	0			57.00
58.00	05800	MRI	0	2,811	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,906	0			59.00
60.00	06000	LABORATORY	0	16,300	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	657	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	2,025	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,225	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,836	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	270	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,054	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,655	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,491	15,294	0			73.00
74.00	07400	RENAL DIALYSIS	0	322	0			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	133	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	550	0			90.00
91.00	09100	EMERGENCY	0	8,785	0			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	206	0			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		261,491	167,846	246	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0			194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)		261,491	167,846	246	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	509,122					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		196,427				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			16,760			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				6,916,920	0	30.00
31.00	03100	INTENSIVE CARE UNIT				483,085	0	31.00
43.00	04300	NURSERY				337,805	0	43.00
44.00	04400	SKILLED NURSING FACILITY				1,289,271	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				2,016,851	0	50.00
51.00	05100	RECOVERY ROOM				320,281	0	51.00
53.00	05300	ANESTHESIOLOGY				12,297	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				524,862	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				233,210	0	55.00
57.00	05700	CT SCAN				54,151	0	57.00
58.00	05800	MRI				93,473	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				340,489	0	59.00
60.00	06000	LABORATORY				755,275	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				749	0	63.00
65.00	06500	RESPIRATORY THERAPY				104,468	0	65.00
66.00	06600	PHYSICAL THERAPY				400,822	0	66.00
69.00	06900	ELECTROCARDIOLOGY				223,247	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				2,449	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				996,998	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				525,440	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				466,590	0	73.00
74.00	07400	RENAL DIALYSIS				9,628	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER				0	0	76.00
76.97	07697	CARDIAC REHABILITATION				114,659	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPS				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				181,779	0	90.00
91.00	09100	EMERGENCY				830,029	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION				10,336	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	17,245,164	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER				182,232	0	194.00
194.01	07951	LAKESHORE GUEST UNIT				0	0	194.01
200.00		Cross Foot Adjustments	509,122	196,427	16,760	722,309	0	200.00
201.00		Negative Cost Centers	0	0	0	122,252	0	201.00
202.00		TOTAL (sum lines 118 through 201)	509,122	196,427	16,760	18,271,957	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	5.05
5.06	00591	ADMINISTRATION & GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
91.01	09101	PARTIAL HOSPITALIZATION	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	194.00
194.01	07951	LAKESHORE GUEST UNIT	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
		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	557,643				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		557,643			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	61,674,338			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	1,090		5.01
5.02	00550	DATA PROCESSING	0	0	0	100	5.02
5.03	00560	PURCHASING, RECEIVING & STORES	11,436	11,436	0	18	5.03
5.04	00570	ADMITTING	0	0	0	32	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	50	5.05
5.06	00591	ADMINISTRATION & GENERAL	153,205	153,205	3,507,145	136	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	89,834	89,834	12,000	46	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4	8.00
9.00	00900	HOUSEKEEPING	10,287	10,287	0	6	9.00
10.00	01000	DIETARY	6,735	6,735	0	8	10.00
11.00	01100	CAFETERIA	10,103	10,103	0	12	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,879	1,879	1,709,382	48	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,205	6,205	254,726	5	14.00
15.00	01500	PHARMACY	3,371	3,371	2,096,448	20	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,543	3,543	26,091	38	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	15	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,633	2,633	8,298,861	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	3,048,929	53	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	328,944	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	117,151	117,151	17,366,244	170	30.00
31.00	03100	INTENSIVE CARE UNIT	6,171	6,171	2,172,161	39	31.00
43.00	04300	NURSERY	4,200	4,200	1,961,437	8	43.00
44.00	04400	SKILLED NURSING FACILITY	24,287	24,287	2,069,778	12	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,664	34,664	4,682,893	82	50.00
51.00	05100	RECOVERY ROOM	6,272	6,272	504,910	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	93,130	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,166	9,166	1,850,139	81	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,554	3,554	1,001,033	0	55.00
57.00	05700	CT SCAN	828	828	287,071	0	57.00
58.00	05800	MRI	1,699	1,699	271,825	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,023	6,023	987,425	0	59.00
60.00	06000	LABORATORY	11,069	11,069	0	58	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	867	867	1,102,867	14	65.00
66.00	06600	PHYSICAL THERAPY	7,028	7,028	1,589,131	28	66.00
69.00	06900	ELECTROCARDIOLOGY	4,328	4,328	282,390	16	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	40,541	13	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	6	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,348	2,348	107,679	3	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,931	2,931	619,317	42	90.00
91.00	09100	EMERGENCY	14,913	14,913	1,973,840	25	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	214,399	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	556,730	556,730	58,460,736	1,090	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	913	913	3,213,602	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	924,400	16,927,234	4,485,855	210,339	9,816,457	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.657691	30.354965	0.072735	192.971560	98,164.570000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:

11/30/2021 12:45 pm

Cost Center Description		PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
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	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING & STORES	22,083,926				5.03
5.04	00570	ADMITTING	0	462,591,704			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	837,262,442		5.05
5.06	00591	ADMINISTRATION & GENERAL	158,796	0	0	-46,687,080	151,187,365
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	5,100
7.00	00700	OPERATION OF PLANT	8,357	0	0	0	12,474,809
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	608,306
9.00	00900	HOUSEKEEPING	2,216	0	0	0	3,904,657
10.00	01000	DIETARY	2,499	0	0	0	1,991,285
11.00	01100	CAFETERIA	0	0	0	0	2,451,735
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	9,080	0	0	0	13,184,171
14.00	01400	CENTRAL SERVICES & SUPPLY	82,556	0	0	0	1,017,328
15.00	01500	PHARMACY	57,897	0	0	0	2,920,197
16.00	01600	MEDICAL RECORDS & LIBRARY	605	0	0	0	275,736
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,563
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	9,523,739
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,075	0	0	0	5,421,372
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	401,101
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	589,455	136,545,269	148,516,094	0	26,649,272
31.00	03100	INTENSIVE CARE UNIT	98,454	17,672,269	17,672,269	0	3,964,087
43.00	04300	NURSERY	16,868	16,479,407	16,479,407	0	2,793,417
44.00	04400	SKILLED NURSING FACILITY	48,701	8,075,907	8,075,907	0	3,211,910
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,634,715	38,661,362	134,017,047	0	9,428,461
51.00	05100	RECOVERY ROOM	3,461	5,826,458	14,459,776	0	853,105
53.00	05300	ANESTHESIOLOGY	27,600	8,228,387	26,987,296	0	153,978
54.00	05400	RADIOLOGY-DIAGNOSTIC	472,260	6,917,194	46,317,836	0	2,546,458
55.00	05500	RADIOLOGY-THERAPEUTIC	10,386	1,315,452	20,736,250	0	1,507,824
57.00	05700	CT SCAN	5,217	9,952,338	23,855,406	0	377,372
58.00	05800	MRI	282	3,334,273	14,055,028	0	384,304
59.00	05900	CARDIAC CATHETERIZATION	182,405	12,326,932	24,530,424	0	1,378,416
60.00	06000	LABORATORY	9,912	43,397,902	81,497,971	0	7,494,486
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,399,690	3,284,069	0	2,827
65.00	06500	RESPIRATORY THERAPY	8,368	9,606,549	10,124,382	0	1,667,381
66.00	06600	PHYSICAL THERAPY	1,127	9,578,915	11,126,025	0	2,131,901
69.00	06900	ELECTROCARDIOLOGY	2,273	9,649,973	24,179,490	0	652,617
70.00	07000	ELECTROENCEPHALOGRAPHY	0	357,808	1,351,749	0	51,222
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,496,762	22,202,695	45,270,545	0	11,662,361
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,020,899	19,345,591	38,274,015	0	6,119,747
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,656,737	76,468,402	0	5,847,177
74.00	07400	RENAL DIALYSIS	0	1,564,131	1,608,864	0	286,692
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	552	382	667,334	0	200,357
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	226	85,891	2,748,911	0	880,157
91.00	09100	EMERGENCY	63,921	16,410,192	43,926,035	0	2,983,215
91.01	09101	PARTIAL HOSPITALIZATION	120	0	1,031,910	0	256,434
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,026,045	462,591,704	837,262,442	-46,687,080	147,672,277
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	57,881	0	0	0	3,515,088
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	246,157	65,190	634,870		46,687,080
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011146	0.000141	0.000758		0.308803

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
204.00		Cost to be allocated (per Wkst. B, Part II)	366,096	0	0		4,907,652	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011042	0.000000	0.000000		0.032461	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: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	
		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	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING&STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE					5.05
5.06	00591	ADMINISTRATION & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS	393,002				6.00
7.00	00700	OPERATION OF PLANT	89,834	303,168			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	925,528		8.00
9.00	00900	HOUSEKEEPING	10,287	10,287	0	292,881	9.00
10.00	01000	DIETARY	6,735	6,735	0	6,735	10.00
11.00	01100	CAFETERIA	10,103	10,103	0	10,103	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,879	1,879	0	1,879	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,205	6,205	483	6,205	14.00
15.00	01500	PHARMACY	3,371	3,371	3,984	3,371	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,543	3,543	0	3,543	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,633	2,633	0	2,633	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	117,151	117,151	320,914	117,151	30.00
31.00	03100	INTENSIVE CARE UNIT	6,171	6,171	8,390	6,171	31.00
43.00	04300	NURSERY	4,200	4,200	67,453	4,200	43.00
44.00	04400	SKILLED NURSING FACILITY	24,287	24,287	60,722	24,287	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,664	34,664	189,993	34,664	50.00
51.00	05100	RECOVERY ROOM	6,272	6,272	9,711	6,272	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,166	9,166	95,882	9,166	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,554	3,554	28,260	3,554	55.00
57.00	05700	CT SCAN	828	828	0	828	57.00
58.00	05800	MRI	1,699	1,699	0	1,699	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,023	6,023	26,821	6,023	59.00
60.00	06000	LABORATORY	11,069	11,069	11	11,069	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	867	867	0	867	65.00
66.00	06600	PHYSICAL THERAPY	7,028	7,028	2,436	7,028	66.00
69.00	06900	ELECTROCARDIOLOGY	4,328	4,328	9,909	4,328	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	598	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,348	2,348	0	2,348	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,931	2,931	8,347	2,931	90.00
91.00	09100	EMERGENCY	14,913	14,913	86,427	14,913	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	392,089	302,255	920,341	291,968	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	913	913	5,187	913	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,675	16,328,593	796,153	5,664,659	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.016985	53.859883	0.860215	19.341162	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	166	3,280,900	19,746	567,418	366,211	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000422	10.822052	0.021335	1.937367	3.157182	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: 14-0224

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

Worksheet B-1

Date/Time Prepared:

11/30/2021 12:45 pm

Cost Center Description			CAFETERIA (MEALS SERV ED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS))	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING & STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	73,957					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,507	0	541,196			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	609	0	18	17,517,661		14.00
15.00	01500	PHARMACY	2,092	0	0	0	5,780,381	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	11,413	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,827	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	520	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,123	0	285,708	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,355	0	47,770	0	0	31.00
43.00	04300	NURSERY	2,221	0	39,514	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,779	0	32,717	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,243	0	63,263	0	0	50.00
51.00	05100	RECOVERY ROOM	1,201	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	222	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,126	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,565	0	9,336	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	294	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,077	0	11,217	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,308	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,760	0	2,080	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	438	0	67	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,496,762	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,020,899	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,780,381	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	106	0	2,203	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,916	0	7,730	0	0	90.00
91.00	09100	EMERGENCY	2,419	0	38,042	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	251	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,478	0	539,665	17,517,661	5,780,381	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	3,479	0	1,531	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,948,560	0	17,473,519	1,819,310	4,183,900	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.389943	0.000000	32.286859	0.103856	0.723810	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		CAFETERIA (MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS))	
		11.00	12.00	13.00	14.00	15.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	531,922	0	523,038	735,079	261,491	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	7.192314	0.000000	0.966448	0.041962	0.045238	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: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED T IME))	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING & STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	837,262,442					16.00
17.00	01700	SOCIAL SERVICE	0	47,793				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			37,008	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	148,516,094	39,820	0	0	27,866	30.00
31.00	03100	INTENSIVE CARE UNIT	17,672,269	2,584	0	0	2,390	31.00
43.00	04300	NURSERY	16,479,407	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,075,907	5,389	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	134,017,047	0	0	0	3,973	50.00
51.00	05100	RECOVERY ROOM	14,459,776	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	26,987,296	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,317,836	0	0	0	743	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,736,250	0	0	0	0	55.00
57.00	05700	CT SCAN	23,855,406	0	0	0	0	57.00
58.00	05800	MRI	14,055,028	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,530,424	0	0	0	0	59.00
60.00	06000	LABORATORY	81,497,971	0	0	0	15	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,284,069	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	10,124,382	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,126,025	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	24,179,490	0	0	0	294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,351,749	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,270,545	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,274,015	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,468,402	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,608,864	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	667,334	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,748,911	0	0	0	26	90.00
91.00	09100	EMERGENCY	43,926,035	0	0	0	1,701	91.00
91.01	09101	PARTIAL HOSPITALIZATION	1,031,910	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	837,262,442	47,793	0	0	37,008	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	622,218	9,898	0	0	13,266,820	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000743	0.207101	0.000000	0.000000	358.485192	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	167,846	246	0	0	509,122	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000200	0.005147	0.000000	0.000000	13.757080	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet B-1
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS APPRV (ASSIGNED T IME))		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING,RECEIVING&STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATION & GENERAL			5.06
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	37,008		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	27,866	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,390	0	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,973	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	743	0	54.00
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	15	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	294	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	26	0	90.00
91.00	09100	EMERGENCY	1,701	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,008	100	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0224

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	7,246,441	552,725	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	195.807420	5,527.250000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	196,427	16,760	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.307690	167.600000	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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 12:45 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	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,016,521	57,016,521	211,353	57,227,874 30.00
31.00	03100	INTENSIVE CARE UNIT	7,415,300	7,415,300	0	7,415,300 31.00
43.00	04300	NURSERY	5,428,179	5,428,179	0	5,428,179 43.00
44.00	04400	SKILLED NURSING FACILITY	7,606,051	7,606,051	0	7,606,051 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,463,525	17,463,525	0	17,463,525 50.00
51.00	05100	RECOVERY ROOM	1,658,989	1,658,989	0	1,658,989 51.00
53.00	05300	ANESTHESIOLOGY	233,432	233,432	4,965	238,397 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,234,329	4,234,329	0	4,234,329 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,658,363	2,658,363	0	2,658,363 55.00
57.00	05700	CT SCAN	572,255	572,255	0	572,255 57.00
58.00	05800	MRI	653,516	653,516	0	653,516 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,706,028	2,706,028	0	2,706,028 59.00
60.00	06000	LABORATORY	10,679,818	10,679,818	0	10,679,818 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,140	6,140	0	6,140 63.00
65.00	06500	RESPIRATORY THERAPY	2,323,110	2,323,110	0	2,323,110 65.00
66.00	06600	PHYSICAL THERAPY	3,476,299	3,476,299	6,817	3,483,116 66.00
69.00	06900	ELECTROCARDIOLOGY	1,223,073	1,223,073	0	1,223,073 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,295	72,295	0	72,295 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,491,373	16,491,373	0	16,491,373 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,663,287	8,663,287	0	8,663,287 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,446,244	12,446,244	0	12,446,244 73.00
74.00	07400	RENAL DIALYSIS	376,418	376,418	0	376,418 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	511,427	511,427	0	511,427 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,727,648	1,727,648	0	1,727,648 90.00
91.00	09100	EMERGENCY	6,460,731	6,460,731	21,014	6,481,745 91.00
91.01	09101	PARTIAL HOSPITALIZATION	349,790	349,790	0	349,790 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,504,758	2,504,758	0	2,504,758 92.00
200.00		Subtotal (see instructions)	174,958,899	174,958,899	244,149	175,203,048 200.00
201.00		Less Observation Beds	2,504,758	2,504,758	0	2,504,758 201.00
202.00		Total (see instructions)	172,454,141	172,454,141	244,149	172,698,290 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 12:45 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	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136,545,269		136,545,269		30.00
31.00	03100	INTENSIVE CARE UNIT	17,672,269		17,672,269		31.00
43.00	04300	NURSERY	16,479,407		16,479,407		43.00
44.00	04400	SKILLED NURSING FACILITY	8,075,907		8,075,907		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	38,661,362	95,355,685	134,017,047	0.130308	50.00
51.00	05100	RECOVERY ROOM	5,826,458	8,633,318	14,459,776	0.114731	51.00
53.00	05300	ANESTHESIOLOGY	8,228,387	18,758,909	26,987,296	0.008650	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,917,194	39,400,642	46,317,836	0.091419	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,315,452	19,420,798	20,736,250	0.128199	55.00
57.00	05700	CT SCAN	9,952,338	13,903,068	23,855,406	0.023988	57.00
58.00	05800	MRI	3,334,273	10,720,755	14,055,028	0.046497	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,326,932	12,203,492	24,530,424	0.110313	59.00
60.00	06000	LABORATORY	43,397,902	38,100,069	81,497,971	0.131044	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,399,690	884,379	3,284,069	0.001870	63.00
65.00	06500	RESPIRATORY THERAPY	9,606,549	517,833	10,124,382	0.229457	65.00
66.00	06600	PHYSICAL THERAPY	9,578,915	1,547,110	11,126,025	0.312448	66.00
69.00	06900	ELECTROCARDIOLOGY	9,649,973	14,529,517	24,179,490	0.050583	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	357,808	993,941	1,351,749	0.053483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,202,695	23,067,850	45,270,545	0.364285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,345,591	18,928,424	38,274,015	0.226349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,656,737	13,811,665	76,468,402	0.162763	73.00
74.00	07400	RENAL DIALYSIS	1,564,131	44,733	1,608,864	0.233965	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	667,334	667,334	0.766373	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	85,891	2,663,020	2,748,911	0.628485	90.00
91.00	09100	EMERGENCY	16,410,192	27,515,843	43,926,035	0.147082	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,031,910	1,031,910	0.338973	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,182,714	10,788,111	11,970,825	0.209239	92.00
200.00		Subtotal (see instructions)	463,774,036	373,488,406	837,262,442		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	463,774,036	373,488,406	837,262,442		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 12:45 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.130308		50.00
51.00	05100	RECOVERY ROOM	0.114731		51.00
53.00	05300	ANESTHESIOLOGY	0.008834		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091419		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.128199		55.00
57.00	05700	CT SCAN	0.023988		57.00
58.00	05800	MRI	0.046497		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110313		59.00
60.00	06000	LABORATORY	0.131044		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.001870		63.00
65.00	06500	RESPIRATORY THERAPY	0.229457		65.00
66.00	06600	PHYSICAL THERAPY	0.313060		66.00
69.00	06900	ELECTROCARDIOLOGY	0.050583		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053483		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.364285		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226349		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.162763		73.00
74.00	07400	RENAL DIALYSIS	0.233965		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.766373		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.628485		90.00
91.00	09100	EMERGENCY	0.147560		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.338973		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209239		92.00
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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
				1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		57,016,521		57,227,874
31.00	03100	INTENSIVE CARE UNIT		7,415,300		7,415,300
43.00	04300	NURSERY		5,428,179		5,428,179
44.00	04400	SKILLED NURSING FACILITY		7,606,051		7,606,051
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		17,463,525		17,463,525
51.00	05100	RECOVERY ROOM		1,658,989		1,658,989
53.00	05300	ANESTHESIOLOGY		233,432	4,965	238,397
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,234,329		4,234,329
55.00	05500	RADIOLOGY-THERAPEUTIC		2,658,363		2,658,363
57.00	05700	CT SCAN		572,255		572,255
58.00	05800	MRI		653,516		653,516
59.00	05900	CARDIAC CATHETERIZATION		2,706,028		2,706,028
60.00	06000	LABORATORY		10,679,818		10,679,818
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0		0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		6,140		6,140
65.00	06500	RESPIRATORY THERAPY	0	2,323,110		2,323,110
66.00	06600	PHYSICAL THERAPY	0	3,476,299	6,817	3,483,116
69.00	06900	ELECTROCARDIOLOGY		1,223,073		1,223,073
70.00	07000	ELECTROENCEPHALOGRAPHY		72,295		72,295
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		16,491,373		16,491,373
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		8,663,287		8,663,287
73.00	07300	DRUGS CHARGED TO PATIENTS		12,446,244		12,446,244
74.00	07400	RENAL DIALYSIS		376,418		376,418
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0		0
76.97	07697	CARDIAC REHABILITATION		511,427		511,427
76.98	07698	HYPERBARIC OXYGEN THERAPY		0		0
76.99	07699	LITHOTRIPSY		0		0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		1,727,648	0	1,727,648
91.00	09100	EMERGENCY		6,460,731	21,014	6,481,745
91.01	09101	PARTIAL HOSPITALIZATION		349,790	0	349,790
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		2,504,758		2,504,758
200.00		Subtotal (see instructions)	0	174,958,899	244,149	175,203,048
201.00		Less Observation Beds		2,504,758		2,504,758
202.00		Total (see instructions)	0	172,454,141	244,149	172,698,290

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136,545,269		136,545,269		30.00
31.00	03100	INTENSIVE CARE UNIT	17,672,269		17,672,269		31.00
43.00	04300	NURSERY	16,479,407		16,479,407		43.00
44.00	04400	SKILLED NURSING FACILITY	8,075,907		8,075,907		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	38,661,362	95,355,685	134,017,047	0.130308	50.00
51.00	05100	RECOVERY ROOM	5,826,458	8,633,318	14,459,776	0.114731	51.00
53.00	05300	ANESTHESIOLOGY	8,228,387	18,758,909	26,987,296	0.008650	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,917,194	39,400,642	46,317,836	0.091419	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,315,452	19,420,798	20,736,250	0.128199	55.00
57.00	05700	CT SCAN	9,952,338	13,903,068	23,855,406	0.023988	57.00
58.00	05800	MRI	3,334,273	10,720,755	14,055,028	0.046497	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,326,932	12,203,492	24,530,424	0.110313	59.00
60.00	06000	LABORATORY	43,397,902	38,100,069	81,497,971	0.131044	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,399,690	884,379	3,284,069	0.001870	63.00
65.00	06500	RESPIRATORY THERAPY	9,606,549	517,833	10,124,382	0.229457	65.00
66.00	06600	PHYSICAL THERAPY	9,578,915	1,547,110	11,126,025	0.312448	66.00
69.00	06900	ELECTROCARDIOLOGY	9,649,973	14,529,517	24,179,490	0.050583	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	357,808	993,941	1,351,749	0.053483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,202,695	23,067,850	45,270,545	0.364285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,345,591	18,928,424	38,274,015	0.226349	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,656,737	13,811,665	76,468,402	0.162763	73.00
74.00	07400	RENAL DIALYSIS	1,564,131	44,733	1,608,864	0.233965	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	667,334	667,334	0.766373	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	85,891	2,663,020	2,748,911	0.628485	90.00
91.00	09100	EMERGENCY	16,410,192	27,515,843	43,926,035	0.147082	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,031,910	1,031,910	0.338973	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,182,714	10,788,111	11,970,825	0.209239	92.00
200.00		Subtotal (see instructions)	463,774,036	373,488,406	837,262,442		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	463,774,036	373,488,406	837,262,442		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,916,920	0	6,916,920	40,806	169.51	30.00
31.00	INTENSIVE CARE UNIT	483,085		483,085	2,658	181.75	31.00
43.00	NURSERY	337,805		337,805	2,096	161.17	43.00
44.00	SKILLED NURSING FACILITY	1,289,271		1,289,271	6,600	195.34	44.00
200.00	Total (lines 30 through 199)	9,027,081		9,027,081	52,160		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	9,151	1,551,186				
31.00	INTENSIVE CARE UNIT	1,118	203,197				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	3,850	752,059				
200.00	Total (lines 30 through 199)	14,119	2,506,442				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part II Date/Time Prepared: 11/30/2021 12:45 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	2,016,851	134,017,047	0.015049	10,860,490	163,440	50.00	
51.00	05100	RECOVERY ROOM	320,281	14,459,776	0.022150	1,576,728	34,925	51.00	
53.00	05300	ANESTHESIOLOGY	12,297	26,987,296	0.000456	2,019,289	921	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	524,862	46,317,836	0.011332	2,846,391	32,255	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	233,210	20,736,250	0.011246	611,963	6,882	55.00	
57.00	05700	CT SCAN	54,151	23,855,406	0.002270	4,210,945	9,559	57.00	
58.00	05800	MRI	93,473	14,055,028	0.006651	1,004,114	6,678	58.00	
59.00	05900	CARDIAC CATHETERIZATION	340,489	24,530,424	0.013880	4,641,010	64,417	59.00	
60.00	06000	LABORATORY	755,275	81,497,971	0.009267	13,931,685	129,105	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	749	3,284,069	0.000228	769,484	175	63.00	
65.00	06500	RESPIRATORY THERAPY	104,468	10,124,382	0.010318	3,176,161	32,772	65.00	
66.00	06600	PHYSICAL THERAPY	400,822	11,126,025	0.036026	1,406,166	50,659	66.00	
69.00	06900	ELECTROCARDIOLOGY	223,247	24,179,490	0.009233	3,898,568	35,995	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	2,449	1,351,749	0.001812	126,141	229	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	996,998	45,270,545	0.022023	6,363,833	140,151	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,440	38,274,015	0.013728	5,617,513	77,117	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	466,590	76,468,402	0.006102	15,468,553	94,389	73.00	
74.00	07400	RENAL DIALYSIS	9,628	1,608,864	0.005984	794,000	4,751	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	114,659	667,334	0.171817	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	181,779	2,748,911	0.066128	32,858	2,173	90.00	
91.00	09100	EMERGENCY	830,029	43,926,035	0.018896	6,085,685	114,995	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	10,336	1,031,910	0.010016	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	302,740	11,970,825	0.025290	0	0	92.00	
200.00		Total (lines 50 through 199)	8,520,823	658,489,590		85,441,577	1,001,588	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/30/2021 12:45 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	40,806	0.00	9,151	30.00		
31.00	03100	INTENSIVE CARE UNIT			0	2,658	0.00	1,118	31.00		
43.00	04300	NURSERY			0	2,096	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY			0	6,600	0.00	3,850	44.00		
200.00		Total (lines 30 through 199)			0	52,160		14,119	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
43.00	04300	NURSERY		0						43.00	
44.00	04400	SKILLED NURSING FACILITY		0						44.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0224

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	552,725	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:45 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	134,017,047	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,459,776	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,987,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	46,317,836	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,736,250	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	23,855,406	0.000000	57.00
58.00	05800	MRI	0	0	0	14,055,028	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	24,530,424	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	81,497,971	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,284,069	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,124,382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,126,025	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,179,490	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,351,749	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,270,545	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,274,015	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	552,725	552,725	76,468,402	0.007228	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,608,864	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	667,334	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,748,911	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,926,035	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	1,031,910	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,970,825	0.000000	92.00
200.00		Total (lines 50 through 199)	0	552,725	552,725	658,489,590		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:45 pm
				Title XVIII	Hospital	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
		9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	10,860,490	0	13,595,717	0
51.00	05100 RECOVERY ROOM	0.000000	1,576,728	0	1,061,949	0
53.00	05300 ANESTHESIOLOGY	0.000000	2,019,289	0	2,791,738	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,846,391	0	7,768,305	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	611,963	0	5,291,782	0
57.00	05700 CT SCAN	0.000000	4,210,945	0	4,356,412	0
58.00	05800 MRI	0.000000	1,004,114	0	2,126,331	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	4,641,010	0	3,775,469	0
60.00	06000 LABORATORY	0.000000	13,931,685	0	7,703,865	0
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	769,484	0	247,124	0
65.00	06500 RESPIRATORY THERAPY	0.000000	3,176,161	0	68,329	0
66.00	06600 PHYSICAL THERAPY	0.000000	1,406,166	0	421,774	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,898,568	0	3,213,316	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	126,141	0	200,861	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,363,833	0	4,061,524	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,617,513	0	3,329,050	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.007228	15,468,553	111,807	2,392,868	17,296
74.00	07400 RENAL DIALYSIS	0.000000	794,000	0	24,462	0
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	327,745	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	32,858	0	509,845	0
91.00	09100 EMERGENCY	0.000000	6,085,685	0	4,068,330	0
91.01	09101 PARTIAL HOSPITALIZATION	0.000000	0	0	137,209	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	1,543,370	0
200.00	Total (lines 50 through 199)		85,441,577	111,807	69,017,375	17,296

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 12:45 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	0.130308	13,595,717	0	2,169	1,771,631	50.00
51.00	05100	RECOVERY ROOM	0.114731	1,061,949	0	0	121,838	51.00
53.00	05300	ANESTHESIOLOGY	0.008650	2,791,738	0	0	24,149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091419	7,768,305	0	63	710,171	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.128199	5,291,782	0	1	678,401	55.00
57.00	05700	CT SCAN	0.023988	4,356,412	0	7,864	104,502	57.00
58.00	05800	MRI	0.046497	2,126,331	0	2,100	98,868	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110313	3,775,469	0	0	416,483	59.00
60.00	06000	LABORATORY	0.131044	7,703,865	3,416	0	1,009,545	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.001870	247,124	4	0	462	63.00
65.00	06500	RESPIRATORY THERAPY	0.229457	68,329	0	0	15,679	65.00
66.00	06600	PHYSICAL THERAPY	0.312448	421,774	0	0	131,782	66.00
69.00	06900	ELECTROCARDIOLOGY	0.050583	3,213,316	0	0	162,539	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053483	200,861	0	0	10,743	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.364285	4,061,524	151,906	5,152	1,479,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226349	3,329,050	38,334	0	753,527	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.162763	2,392,868	0	20,855	389,470	73.00
74.00	07400	RENAL DIALYSIS	0.233965	24,462	0	0	5,723	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.766373	327,745	0	0	251,175	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.628485	509,845	0	1	320,430	90.00
91.00	09100	EMERGENCY	0.147082	4,068,330	0	15	598,378	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.338973	137,209	0	0	46,510	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209239	1,543,370	0	0	322,933	92.00
200.00		Subtotal (see instructions)		69,017,375	193,660	38,220	9,424,491	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		69,017,375	193,660	38,220	9,424,491	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 12:45 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	283		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	6		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	189		57.00
58.00	05800	MRI	0	98		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	448	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,337	1,877		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,677	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,394		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1		90.00
91.00	09100	EMERGENCY	0	2		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	64,462	5,850		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	64,462	5,850		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:45 pm	
				Title XVIII		Skilled Nursing Facility		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
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	552,725	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0	0	0	0	0	91.01
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	552,725	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:45 pm	
			Title XVIII		Skilled Nursing Facility		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	134,017,047	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,459,776	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,987,296	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	46,317,836	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	20,736,250	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	23,855,406	0.000000	57.00
58.00	05800	MRI	0	0	0	14,055,028	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	24,530,424	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	81,497,971	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,284,069	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,124,382	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,126,025	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,179,490	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,351,749	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,270,545	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,274,015	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	552,725	552,725	76,468,402	0.007228	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,608,864	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	667,334	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,748,911	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,926,035	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	1,031,910	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,970,825	0.000000	92.00
200.00		Total (lines 50 through 199)	0	552,725	552,725	658,489,590		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0224 Component CCN: 14-5568		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 12:45 pm	
				Title XVIII		Skilled Nursing Facility		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	10,737	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0.000000	31,309	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	159,013	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	87,063	0	0	0	55.00
57.00	05700	CT SCAN		0.000000	58,163	0	0	0	57.00
58.00	05800	MRI		0.000000	4,887	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	1,361,958	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	10,539	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	3,662,727	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	90,155	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	2,973	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	624,461	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.007228	2,224,095	16,076	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY		0.000000	8,759	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION		0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			8,336,839	16,076	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-5568

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/30/2021 12:45 pm

Title XVIII

Skilled Nursing
Facility

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	0.130308	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.114731	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.008650	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.091419	0	0	11	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.128199	0	0	0	0 55.00
57.00	05700 CT SCAN	0.023988	0	0	29	0 57.00
58.00	05800 MRI	0.046497	0	0	3	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.110313	0	0	0	0 59.00
60.00	06000 LABORATORY	0.131044	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.001870	0	0	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.229457	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.312448	0	0	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	0.050583	0	0	5	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053483	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.364285	0	0	2	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.226349	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.162763	0	0	3,585	0 73.00
74.00	07400 RENAL DIALYSIS	0.233965	0	0	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.766373	0	0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.628485	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.147082	0	0	0	0 91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.338973	0	0	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209239	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	3,635	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	0	3,635	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224

Period:

Worksheet D

Component CCN: 14-5568

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/30/2021 12:45 pm

Title XVIII

Skilled Nursing
Facility

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	1	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	1	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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	584	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	587	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	587	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:45 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)			40,806	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			40,806	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)			39,020	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)			9,151	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)			57,227,874	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)			57,227,874	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)			57,227,874	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)			1,402.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			12,833,728	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)			12,833,728	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:45 pm	
				Title XVIII		Hospital	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,415,300	2,658	2,789.80	1,118	3,118,996	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)					13,024,232	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					28,976,956	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)					1,754,383	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,113,395	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,867,778	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					26,109,178	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,786	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,402.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,504,758	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,916,920	57,227,874	0.120866	2,504,758	302,740
91.00	Nursing School cost	0	57,227,874	0.000000	2,504,758	0
92.00	Allied health cost	0	57,227,874	0.000000	2,504,758	0
93.00	All other Medical Education	0	57,227,874	0.000000	2,504,758	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:45 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,600	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,600	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)		6,600	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)		3,850	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,606,051	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,606,051	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,606,051	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 12:45 pm
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					
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)					
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					
52.00 Total Program excludable cost (sum of lines 50 and 51)					
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					
55.00 Target amount per discharge					
56.00 Target amount (line 54 x line 55)					
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					
58.00 Bonus payment (see instructions)					
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					
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)					
62.00 Relief payment (see instructions)					
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					
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)					
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					
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)					
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)					
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					
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)					7,606,051
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					1,152.43
72.00 Program routine service cost (line 9 x line 71)					4,436,856
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					4,436,856
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00
77.00 Program capital-related costs (line 9 x line 76)					0
78.00 Inpatient routine service cost (line 74 minus line 77)					0
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0
81.00 Inpatient routine service cost per diem limitation					0.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0
83.00 Reasonable inpatient routine service costs (see instructions)					4,436,856
84.00 Program inpatient ancillary services (see instructions)					1,949,638
85.00 Utilization review - physician compensation (see instructions)					0
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					6,386,494
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

 Provider CCN: 14-0224
 Component CCN: 14-5568

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

 Worksheet D-1
 Date/Time Prepared:
 11/30/2021 12:45 pm
 PPS

Title XVIII

 Skilled Nursing
 Facility

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:

11/30/2021 12:45 pm

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	40,806	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	40,806	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)	39,020	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,625	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,096	15.00
16.00	Nursery days (title V or XIX only)	282	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)	57,016,521	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)	57,016,521	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)	57,016,521	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)	1,397.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,667,808	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,667,808	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 12:45 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	5,428,179	2,096	2,589.78	282	730,318	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,415,300	2,658	2,789.80	110	306,878	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						4,705,004 49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge						0.00 55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						1,786 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,397.26 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,495,506 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 12:45 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	6,916,920	57,016,521	0.121314	2,495,506	302,740	90.00
91.00	Nursing School cost	0	57,016,521	0.000000	2,495,506	0	91.00
92.00	Allied health cost	0	57,016,521	0.000000	2,495,506	0	92.00
93.00	All other Medical Education	0	57,016,521	0.000000	2,495,506	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 12:45 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		34,131,790		30.00
31.00	03100	INTENSIVE CARE UNIT		6,930,396		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.130308	10,860,490	1,415,209	50.00
51.00	05100	RECOVERY ROOM	0.114731	1,576,728	180,900	51.00
53.00	05300	ANESTHESIOLOGY	0.008834	2,019,289	17,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091419	2,846,391	260,214	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.128199	611,963	78,453	55.00
57.00	05700	CT SCAN	0.023988	4,210,945	101,012	57.00
58.00	05800	MRI	0.046497	1,004,114	46,688	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110313	4,641,010	511,964	59.00
60.00	06000	LABORATORY	0.131044	13,931,685	1,825,664	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.001870	769,484	1,439	63.00
65.00	06500	RESPIRATORY THERAPY	0.229457	3,176,161	728,792	65.00
66.00	06600	PHYSICAL THERAPY	0.313060	1,406,166	440,214	66.00
69.00	06900	ELECTROCARDIOLOGY	0.050583	3,898,568	197,201	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053483	126,141	6,746	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.364285	6,363,833	2,318,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.226349	5,617,513	1,271,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.162763	15,468,553	2,517,708	73.00
74.00	07400	RENAL DIALYSIS	0.233965	794,000	185,768	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.766373	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.628485	32,858	20,651	90.00
91.00	09100	EMERGENCY	0.147560	6,085,685	898,004	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.338973	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.209239	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		85,441,577	13,024,232	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)		85,441,577		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 12:45 pm	
		Title XVIII	Skilled Nursing Facility	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
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.130308	10,737	1,399	50.00
51.00	05100 RECOVERY ROOM	0.114731	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.008834	31,309	277	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.091419	159,013	14,537	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.128199	87,063	11,161	55.00
57.00	05700 CT SCAN	0.023988	58,163	1,395	57.00
58.00	05800 MRI	0.046497	4,887	227	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.110313	0	0	59.00
60.00	06000 LABORATORY	0.131044	1,361,958	178,476	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.001870	10,539	20	63.00
65.00	06500 RESPIRATORY THERAPY	0.229457	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.313060	3,662,727	1,146,653	66.00
69.00	06900 ELECTROCARDIOLOGY	0.050583	90,155	4,560	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053483	2,973	159	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.364285	624,461	227,482	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.226349	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.162763	2,224,095	362,000	73.00
74.00	07400 RENAL DIALYSIS	0.233965	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.766373	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.628485	0	0	90.00
91.00	09100 EMERGENCY	0.147560	8,759	1,292	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.338973	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.209239	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,336,839	1,949,638	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)		8,336,839		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:45 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)		4,688,721	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		12,701,342	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)		34,473	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		432,888	2.04
3.00	Managed Care Simulated Payments		8,868,478	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		248.09	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)		180.90	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)		22.76	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.		0.64	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)		7.00	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)		164.50	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		104.18	10.00
11.00	FTE count for residents in dental and podiatric programs.		12.79	11.00
12.00	Current year allowable FTE (see instructions)		116.97	12.00
13.00	Total allowable FTE count for the prior year.		116.15	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.		118.77	14.00
15.00	Sum of lines 12 through 14 divided by 3.		117.30	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		117.30	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.472812	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.453706	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.453706	21.00
22.00	IME payment adjustment (see instructions)		3,840,717	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,958,665	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)		-60.32	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)		3,840,717	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,958,665	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.64	31.00
32.00	Sum of lines 30 and 31		31.64	32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.32	33.00
34.00	Disproportionate share adjustment (see instructions)		666,040	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:45 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)	1,053,614	547,542		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	264,843	409,531		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	674,374			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)	23,038,555			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)		24,997,220		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,964,099		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).		4,657,211		52.00
53.00	Nursing and Allied Health Managed Care payment		12,330		53.00
54.00	Special add-on payments for new technologies		23,445		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)		111,807		58.00
59.00	Total (sum of amounts on lines 49 through 58)		31,766,112		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		31,766,112		61.00
62.00	Deductibles billed to program beneficiaries		1,843,768		62.00
63.00	Coinsurance billed to program beneficiaries		87,398		63.00
64.00	Allowable bad debts (see instructions)		756,012		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		491,408		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		417,806		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		30,326,354		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		186,056		70.93
70.94	HRR adjustment amount (see instructions)		-44,874		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 12:45 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)		30,467,536	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		30,191,341	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)		276,195	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		424,471	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 12:45 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
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,688,721	0	4,688,721		4,688,721
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,701,342	0		12,701,342	12,701,342
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	34,473	0	34,473		34,473
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	432,888	0		432,888	432,888
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	8,868,478	0	2,337,747	6,530,731	8,868,478
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.453706	0.453706	0.453706	0.453706	
6.00	IME payment adjustment (see instructions)	22.00	3,840,717	0	1,035,537	2,805,180	3,840,717
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,958,665	0	516,308	1,442,357	1,958,665
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	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	3,840,717	0	1,035,537	2,805,180	3,840,717
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,958,665	0	516,308	1,442,357	1,958,665
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1532	0.1532	0.1532	0.1532	
11.00	Disproportionate share adjustment (see instructions)	34.00	666,040	0	179,578	486,462	666,040
11.01	Uncompensated care payments	36.00	674,374	0	2,560,008	0	2,560,008
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	23,038,555	0	8,498,317	14,540,238	23,038,555
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,997,220	0	9,014,625	15,982,595	24,997,220
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,964,099	0	2,489,838	-525,739	1,964,099

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 12:45 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	23,445	0	0	23,445	23,445	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	11,504,463	15,480,301	26,984,764	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	1,346,416	0	1,718,288	-371,872	1,346,416	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	172,423	0	203,312	-30,889	172,423	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	0.3307	0.3307	0.3307	0.3307		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	445,260	0	568,238	-122,978	445,260	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,964,099	0	2,489,838	-525,739	1,964,099	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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 12:45 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	4,688,721	4,688,721		4,688,721	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	12,701,342		12,701,342	12,701,342	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	34,473	34,473		34,473	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	432,888		432,888	432,888	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,868,478	2,337,747	6,530,730	8,868,477	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.453706	0.453706	0.453706		5.00
6.00	IME payment adjustment (see instructions)	22.00	3,840,717	1,035,537	2,805,180	3,840,717	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,958,665	516,308	1,442,357	1,958,665	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	3,840,717	1,035,537	2,805,180	3,840,717	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,958,665	516,308	1,442,357	1,958,665	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1532	0.1532	0.1532		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	666,040	179,578	486,462	666,040	11.00
11.01	Uncompensated care payments	36.00	674,374	469,017	1,264,927	1,733,944	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	23,038,555	6,407,326	16,631,229	23,038,555	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	24,997,220	6,923,634	18,073,586	24,997,220	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,964,099	2,489,838	-525,739	1,964,099	16.00
17.00	Special add-on payments for new technologies	54.00	23,445	0	23,445	23,445	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,413,472	17,571,292	26,984,764	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 12:45 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	1,346,416	1,718,288	-371,872	1,346,416	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	172,423	203,312	-30,889	172,423	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	0.3307	0.3307	0.3307		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	445,260	568,238	-122,978	445,260	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,964,099	2,489,838	-525,739	1,964,099	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	186,056	20,133	165,923	186,056	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	-44,874	-16,879	-27,995	-44,874	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: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 12:45 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		70,312	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,407,195	2.00
3.00	OPPS payments		7,580,754	3.00
4.00	Outlier payment (see instructions)		78,217	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		17,296	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		70,312	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		231,880	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)		231,880	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)		231,880	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		161,568	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)		70,312	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)		7,676,267	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		38,048	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,476,235	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)		6,232,296	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,232,684	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)		7,464,980	30.00
31.00	Primary payer payments		1,340	31.00
32.00	Subtotal (line 30 minus line 31)		7,463,640	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)		313,335	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		203,668	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		206,953	36.00
37.00	Subtotal (see instructions)		7,667,308	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,667,308	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		7,909,135	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)		-241,827	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		1,403	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: 14-0224 Component CCN: 14-5568	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 12:45 pm
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		587	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		587	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,635	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		3,635	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 charge basis 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)		3,635	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,048	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)		587	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	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)			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)		587	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)		587	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		587	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)		587	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		587	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		945	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-358	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 12:45 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		24,835,227		6,186,525	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		5,301,834		1,722,610	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	11/02/2020	54,280		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)		54,280		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)		30,191,341		7,909,135	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		276,195		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		241,827	6.02
7.00	Total Medicare program liability (see instructions)		30,467,536		7,667,308	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: 14-0224
Component CCN: 14-5568

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

Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 12:45 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,369,028		945	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)		2,369,028		945	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		18,071		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		358	6.02
7.00	Total Medicare program liability (see instructions)		2,387,099		587	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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 12:45 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: 14-0224 Component CCN: 14-5568	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 11/30/2021 12:45 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,439,635	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		16,076	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,455,711	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		70,607	7.00
8.00	Allowable bad debts (see instructions)		3,069	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		1,995	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		2,387,099	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		2,387,099	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		2,369,028	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		18,071	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 12:45 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	4,705,004			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,705,004		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,705,004		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	0		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	0		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	4,705,004		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	4,705,004		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinsurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	0		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		0	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0224		Period: From 07/01/2020 To 06/30/2021		Worksheet E-4 Date/Time Prepared: 11/30/2021 12:45 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.					142.44	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					23.61	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					1.79	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))					-19.46	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)					7.00	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)					104.58	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					104.18	6.00
7.00	Enter the lesser of line 5 or line 6					104.18	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.	86.81	17.37	104.18		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.	86.81	17.37	104.18		9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year		12.79			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	86.81	30.16			11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	87.34	27.86			12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	88.20	29.03			13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	87.45	29.02			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	87.45	29.02			17.00	
18.00	Per resident amount	143,329.33	138,154.39			18.00	
19.00	Approved amount for resident costs	12,534,150	4,009,240	16,543,390		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)			16,543,390		25.00	
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	10,269	2,379	2,610			26.00
27.00	Total Inpatient Days (see instructions)	42,286	42,286	42,286			27.00
28.00	Ratio of inpatient days to total inpatient days	0.242846	0.056260	0.061723			28.00
29.00	Program direct GME amount	4,017,496	930,731	1,021,108	5,969,335	29.00	
29.01	Percent reduction for MA DGME		4.07	4.07			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		37,881	41,559	79,440	30.00	
31.00	Net Program direct GME amount				5,889,895	31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/30/2021 12:45 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)		1,608,864	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)		35,869,523	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		35,869,523	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		9,495,390	42.00
43.00	Primary payer payments (see instructions)		1,340	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		9,494,050	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		45,363,573	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.790712	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.209288	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		5,889,895	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		4,657,211	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,232,684	50.00

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

Provider CCN: 14-0224

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

Worksheet G

Date/Time Prepared:
11/30/2021 12:45 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	9,701	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	86,639,325	0	0	0	4.00
5.00	Other receivable	88,660	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-60,875,950	0	0	0	6.00
7.00	Inventory	3,404,181	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,561,784	0	0	0	9.00
10.00	Due from other funds	9,749,341	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,577,042	0	0	0	11.00
FIXED ASSETS						
12.00	Land	26,070,000	0	0	0	12.00
13.00	Land improvements	462,328	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	82,708,276	0	0	0	15.00
16.00	Accumulated depreciation	0	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	17,008,601	0	0	0	23.00
24.00	Accumulated depreciation	-20,700,605	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	105,548,600	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,785,424	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	68,381,314	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	70,166,738	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	216,292,380	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,246,465	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,385,779	0	0	0	38.00
39.00	Payroll taxes payable	2,495,848	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	530,396	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	64,969,878	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	72,628,366	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	78,680,235	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	78,680,235	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	151,308,601	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	64,983,781	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	64,983,781	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	216,292,382	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0224

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

Worksheet G-1

Date/Time Prepared:
11/30/2021 12:45 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		54,820,572		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,533,079				2.00
3.00	Total (sum of line 1 and line 2)		46,287,493		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION	1,189,260		0		0	5.00
6.00	TRANSFER FROM AFFILIATE	18,237,028		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)		19,426,288		0		10.00
11.00	Subtotal (line 3 plus line 10)		65,713,781		0		11.00
12.00	NET ASSET TRANSFER	0		0		0	12.00
13.00	TRANSFER FROM AFFILIATE	730,000		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)		730,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		64,983,781		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION		0				5.00
6.00	TRANSFER FROM AFFILIATE		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	NET ASSET TRANSFER		0				12.00
13.00	TRANSFER FROM AFFILIATE		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: 14-0224

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 12:45 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	153,024,676		153,024,676	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	8,075,907		8,075,907	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)	161,100,583		161,100,583	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	17,672,269		17,672,269	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)	17,672,269		17,672,269	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	178,772,852		178,772,852	17.00
18.00	Ancillary services	267,322,388	331,489,523	598,811,911	18.00
19.00	Outpatient services	17,678,797	41,998,884	59,677,681	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER MISC REVENUES	31,166	18,002,452	18,033,618	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	463,805,203	391,490,859	855,296,062	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		219,682,946		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00	RECONCILING ITEM	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)		219,682,946		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0224

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

Worksheet G-3

Date/Time Prepared:
11/30/2021 12:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	855,296,062	1.00
2.00	Less contractual allowances and discounts on patients' accounts	671,553,414	2.00
3.00	Net patient revenues (line 1 minus line 2)	183,742,648	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	219,682,946	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-35,940,298	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SOURCES	3,610,613	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	0	24.01
24.50	COVID-19 PHE Funding	23,996,606	24.50
25.00	Total other income (sum of lines 6-24)	27,607,219	25.00
26.00	Total (line 5 plus line 25)	-8,333,079	26.00
27.00	RESTRUCT AND IMPAIR COSTS	200,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	200,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,533,079	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0224	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/30/2021 12:45 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,346,416	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		172,423	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)		115.85	3.00
4.00	Number of interns & residents (see instructions)		117.30	4.00
5.00	Indirect medical education percentage (see instructions)		33.07	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)		445,260	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,964,099	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