

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: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 7/28/2022 12:38 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2022	Time: 12:38 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY FIRST MEDICAL CENTER (14-0251) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-20,890	-305,288	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	0	-4		0	7.00
200.00	Total	0	-20,890	-305,292	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: 14-0251		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2022 12:38 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5645 WEST ADDISON ST.			PO Box:				1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60634		County: COOK		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		COMMUNITY FIRST MEDICAL CENTER	140251	16984	1	07/01/1966	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		CFMC SKILLED NURSING FACILITY	145548	16974		07/01/1985	N	P	O
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021		20.00
21.00	Type of Control (see instructions)						4			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00

Worksheet S-2
Part I
Date/Time Prepared:
7/28/2022 12:38 am

MCRIF32 - 17.8.174.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0251		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2022 12:38 am			
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
			1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00		
			Y/N	IME	Direct GME	IME	Direct GME		
			1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
							1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
			1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
7/28/2022 12:38 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	2.88	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,625,363	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0251		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 7/28/2022 12:38 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00		
142.00	Street:	PO Box:						142.00		
143.00	City:	State:			Zip Code:			143.00		
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		155.00
156.00	Subprovider - IPF	N		N		N		N		156.00
157.00	Subprovider - IRF	N		N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF	N		N		N		N		159.00
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00
161.00	CMHC			N		N		N		161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00	
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0251		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 7/28/2022 12:38 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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	04/13/2022	Y	04/13/2022		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/28/2022 12:38 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 X 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
7/28/2022 12:38 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	193	70,445	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)		193	70,445	0.00	0	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	34.00	20	7,300	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		213	77,745	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	66	24,090		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)		279			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,146	2,394	20,435			1.00
2.00	HMO and other (see instructions)	5,185	3,260				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)	7,146	2,394	20,435			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	1,589	503	4,239			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	8,735	2,897	24,674	2.88	627.70	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	6,921	0	9,762	0.00	28.86	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)			45			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)				2.88	656.56	27.00
28.00	Observation Bed Days		82	2,504			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,308	437	3,727	1.00
2.00 HMO and other (see instructions)			729	518		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	1,308	437	3,727	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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/28/2022 12:38 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	45,007,135	0	45,007,135	1,365,632.00	32.96	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,449,311	0	1,449,311	7,152.00	202.64	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	2,053,445	0	2,053,445	60,025.00	34.21	9.00
10.00	Excluded area salaries (see instructions)		265,888	0	265,888	4,315.00	61.62	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,519,462	0	2,519,462	27,527.00	91.53	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,888,601	0	6,888,601			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		342,476	0	342,476			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		38,070	0	38,070			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
7/28/2022 12:38 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	452,509	0	452,509	10,235.00	44.21	26.00
27.00	Administrative & General	5.00	4,263,885	0	4,263,885	162,736.00	26.20	27.00
28.00	Administrative & General under contract (see inst.)		313,490	0	313,490	2,770.00	113.17	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,501,703	0	1,501,703	65,863.00	22.80	30.00
31.00	Laundry & Linen Service	8.00	103,899	0	103,899	6,034.00	17.22	31.00
32.00	Housekeeping	9.00	1,525,373	0	1,525,373	87,646.00	17.40	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	960,561	-216,863	743,698	40,390.00	18.41	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	216,863	216,863	11,780.00	18.41	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,634,674	0	1,634,674	35,987.00	45.42	38.00
39.00	Central Services and Supply	14.00	495,723	0	495,723	26,799.00	18.50	39.00
40.00	Pharmacy	15.00	1,778,172	0	1,778,172	46,131.00	38.55	40.00
41.00	Medical Records & Medical Records Library	16.00	2,419,346	0	2,419,346	63,157.00	38.31	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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
7/28/2022 12:38 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	43,871,314	0	43,871,314	1,361,250.00	32.23	1.00
2.00	Excluded area salaries (see instructions)	2,319,333	0	2,319,333	64,340.00	36.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,551,981	0	41,551,981	1,296,910.00	32.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,519,462	0	2,519,462	27,527.00	91.53	4.00
5.00	Subtotal wage-related costs (see inst.)	6,888,601	0	6,888,601	0.00	16.58	5.00
6.00	Total (sum of lines 3 thru 5)	50,960,044	0	50,960,044	1,324,437.00	38.48	6.00
7.00	Total overhead cost (see instructions)	15,449,335	0	15,449,335	559,528.00	27.61	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 7/28/2022 12:38 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,581 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			2,758,382 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			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			27,985 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)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			977,497 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			3,460,607 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			43,095 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			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			7,269,147 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,519,462	7,269,147	1.00
2.00	Hospital	2,519,462	7,269,147	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	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0251

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

Worksheet S-10

Date/Time Prepared:
7/28/2022 12:38 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.196565	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		24,782,037	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		139,329,097	6.00
7.00	Medicaid cost (line 1 times line 6)		27,387,224	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)		2,605,187	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)		2,605,187	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)	24,549,317	102,579	24,651,896
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,825,536	102,579	4,928,115
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	4,825,536	102,579	4,928,115
			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)		5,619,822	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		340,202	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		523,388	27.01
28.00	Non-Medicare bad debt expense (see instructions)		5,096,434	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,184,967	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,113,082	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,718,269	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0251

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

Worksheet A

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,595,804	1,595,804	541,263	2,137,067	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,368,611	2,368,611	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	452,509	3,089,102	3,541,611	977,497	4,519,108	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,263,885	25,458,203	29,722,088	-3,445,929	26,276,159	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,501,703	2,205,325	3,707,028	-55,590	3,651,438	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,899	510,056	613,955	0	613,955	8.00
9.00	00900	HOUSEKEEPING	1,525,373	529,095	2,054,468	0	2,054,468	9.00
10.00	01000	DIETARY	960,561	717,262	1,677,823	-378,797	1,299,026	10.00
11.00	01100	CAFETERIA	0	0	0	378,797	378,797	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,634,674	171,006	1,805,680	0	1,805,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	495,723	194,486	690,209	-157,418	532,791	14.00
15.00	01500	PHARMACY	1,778,172	4,321,129	6,099,301	-4,020,058	2,079,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,419,346	520,055	2,939,401	0	2,939,401	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	238,433	238,433	0	238,433	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	7,549,234	2,334,921	9,884,155	361,020	10,245,175	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,949,094	1,143,521	4,092,615	453,846	4,546,461	34.00
44.00	04400	SKILLED NURSING FACILITY	2,053,445	953,936	3,007,381	-7,003	3,000,378	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,141,836	2,670,229	4,812,065	-1,724,370	3,087,695	50.00
51.00	05100	RECOVERY ROOM	439,311	37,046	476,357	-1,160	475,197	51.00
53.00	05300	ANESTHESIOLOGY	55,702	1,556,605	1,612,307	-28,535	1,583,772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419,875	277,707	1,697,582	-27,194	1,670,388	54.00
56.00	05600	RADIOISOTOPE	184,816	124,344	309,160	-2,066	307,094	56.00
57.00	05700	CT SCAN	532,538	168,692	701,230	-22,560	678,670	57.00
58.00	05800	MRI	163,502	80,989	244,491	-4,560	239,931	58.00
59.00	05900	CARDIAC CATHETERIZATION	841,653	755,962	1,597,615	-728,376	869,239	59.00
60.00	06000	LABORATORY	1,984,319	3,234,568	5,218,887	-6,895	5,211,992	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,079,561	824,691	1,904,252	-260,881	1,643,371	65.00
66.00	06600	PHYSICAL THERAPY	877,909	79,305	957,214	-8,930	948,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	439,589	35,209	474,798	0	474,798	67.00
68.00	06800	SPEECH PATHOLOGY	152,707	11,885	164,592	0	164,592	68.00
69.00	06900	ELECTROCARDIOLOGY	362,044	43,834	405,878	-6,294	399,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,886	3,847	46,733	0	46,733	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,579,727	1,579,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,464,644	1,464,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,020,058	4,020,058	73.00
74.00	07400	RENAL DIALYSIS	246,012	30,274	276,286	0	276,286	74.00
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	641,078	57,789	698,867	-3,405	695,462	90.00
91.00	09100	EMERGENCY	5,448,291	5,563,081	11,011,372	-1,255,442	9,755,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,741,247	59,538,391	104,279,638	0	104,279,638	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	265,888	337,537	603,425	0	603,425	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	45,007,135	59,875,928	104,883,063	0	104,883,063	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0251

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

Worksheet A

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,137,067	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,368,611	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,519,108	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,574,178	18,701,981	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-300	3,651,138	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	613,955	8.00
9.00	00900	HOUSEKEEPING	0	2,054,468	9.00
10.00	01000	DIETARY	0	1,299,026	10.00
11.00	01100	CAFETERIA	-194,982	183,815	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,805,680	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	532,791	14.00
15.00	01500	PHARMACY	0	2,079,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,440	2,937,961	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	238,433	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,219,470	9,025,705	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-216,056	4,330,405	34.00
44.00	04400	SKILLED NURSING FACILITY	0	3,000,378	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-406,317	2,681,378	50.00
51.00	05100	RECOVERY ROOM	0	475,197	51.00
53.00	05300	ANESTHESIOLOGY	-1,522,536	61,236	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,020	1,661,368	54.00
56.00	05600	RADIOISOTOPE	0	307,094	56.00
57.00	05700	CT SCAN	0	678,670	57.00
58.00	05800	MRI	0	239,931	58.00
59.00	05900	CARDIAC CATHETERIZATION	-2,920	866,319	59.00
60.00	06000	LABORATORY	0	5,211,992	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-32,393	1,610,978	65.00
66.00	06600	PHYSICAL THERAPY	0	948,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	474,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	164,592	68.00
69.00	06900	ELECTROCARDIOLOGY	0	399,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	46,733	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,579,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,464,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,020,058	73.00
74.00	07400	RENAL DIALYSIS	0	276,286	74.00
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	695,462	90.00
91.00	09100	EMERGENCY	-5,296,103	4,459,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,475,715	87,803,923	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	603,425	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,475,715	88,407,348	200.00

RECLASSIFICATIONS

Provider CCN: 14-0251

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

Worksheet A-6

Date/Time Prepared:
7/28/2022 12:38 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COST					
1.00	CAFETERIA	11.00	216,863	161,934		1.00
	0		216,863	161,934		
	B - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	751,822		1.00
	0		0	751,822		
	C - CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1,579,727		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	1,464,644		2.00
	PATIENTS					
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	3,044,371		
	D - INSURNACE EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,929		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	91,668		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	977,497		3.00
	0		0	1,218,094		
	E - CHARGEABLE DRUG COST					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,020,058		1.00
	0		0	4,020,058		
	F - INTEREST EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,144,156		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	968,037		2.00
	TOTALS		0	2,112,193		
	H - EQUIPMENT LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	557,084		1.00
2.00	OPERATING ROOM	50.00	0	19,961		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
	0		0	577,045		
	I - ROUTINE IN ANCILLARY					
1.00	ADULTS & PEDIATRICS	30.00	451,668	71,818		1.00
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	463,927	73,768		2.00
	TOTALS		915,595	145,586		
500.00	Grand Total: Increases		1,132,458	12,031,103		500.00

RECLASSIFICATIONS

Provider CCN: 14-0251

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

Worksheet A-6

Date/Time Prepared:
7/28/2022 12:38 am

	Decreases					17/28/2022 12:38 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS CAFETERIA COST					
1.00	DIETARY	10.00	216,863	161,934	0	1.00
	0		216,863	161,934		
	B - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	751,822	9	1.00
	0		0	751,822		
	C - CHARGEABLE MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	111,480	0	1.00
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	74,236	0	2.00
3.00	OPERATING ROOM	50.00	0	1,744,331	0	3.00
4.00	RECOVERY ROOM	51.00	0	1,160	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	28,535	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	27,194	0	6.00
7.00	RADIOISOTOPE	56.00	0	2,066	0	7.00
8.00	CT SCAN	57.00	0	22,560	0	8.00
9.00	MRI	58.00	0	4,560	0	9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	717,306	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	101,519	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	8,930	0	12.00
13.00	ELECTROCARDIOLOGY	69.00	0	6,294	0	13.00
14.00	CLINIC	90.00	0	3,405	0	14.00
15.00	EMERGENCY	91.00	0	190,795	0	15.00
	0		0	3,044,371		
	D - INSURNACE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,218,094	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	0	3.00
	0		0	1,218,094		
	E - CHARGEABLE DRUG COST					
1.00	PHARMACY	15.00	0	4,020,058	0	1.00
	0		0	4,020,058		
	F - INTEREST EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,112,193	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	2,112,193		
	H - EQUIPMENT LEASE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	115,642	10	1.00
2.00	OPERATION OF PLANT	7.00	0	55,590	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	157,418	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	50,986	0	4.00
5.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	9,613	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	0	7,003	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	11,070	0	7.00
8.00	LABORATORY	60.00	0	6,895	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	159,362	0	9.00
10.00	EMERGENCY	91.00	0	3,466	0	10.00
	0		0	577,045		
	I - ROUTINE IN ANCILLARY					
1.00	EMERGENCY	91.00	915,595	145,586	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		915,595	145,586		
500.00	Grand Total: Decreases		1,132,458	12,031,103		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
7/28/2022 12:38 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,492,384	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,304,602	243,666	0	243,666	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,817,883	0	0	0	16,820,362	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,614,869	243,666	0	243,666	16,820,362	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	45,614,869	243,666	0	243,666	16,820,362	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,492,384	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	16,548,268	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,997,521	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	29,038,173	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	29,038,173	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,137,629	0	458,175	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)	1,137,629	0	458,175	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,595,804				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,595,804				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,548,268	0	16,548,268	0.623386	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,997,521	0	9,997,521	0.376614	0	2.00
3.00	Total (sum of lines 1-2)	26,545,789	0	26,545,789	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	385,807	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	751,822	557,084	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,137,629	557,084	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	1,602,331	148,929	0	0	2,137,067	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	968,037	91,668	0	0	2,368,611	2.00
3.00	Total (sum of lines 1-2)	2,570,368	240,597	0	0	4,505,678	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0251

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

Worksheet A-8

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-12,727	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,345	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,350,687			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-194,982	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	-1,440	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-33,255	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-41,867	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0251

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

Worksheet A-8

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	MISC INCOME	B	-300	OPERATION OF PLANT	7.00	0	34.00
35.00	MISC INCOME	B	-306	SURGICAL INTENSIVE CARE UNIT	34.00	0	35.00
36.00	MISC INCOME	B	-67	OPERATING ROOM	50.00	0	36.00
37.00	MISC INCOME	B	-9,020	RADIOLOGY-DIAGNOSTIC	54.00	0	37.00
38.00	MISC INCOME	B	-2,920	CARDIAC CATHETERIZATION	59.00	0	38.00
39.00	MISC INCOME	B	-413	EMERGENCY	91.00	0	39.00
40.00	MEDICAID TAX ASSESSMENTS	B	-7,354,239	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PT B PHYSICIANS	A	-259,365	ADULTS & PEDIATRICS	30.00	0	41.00
42.00	PT B PHYSICIANS	A	-1,048,782	EMERGENCY	91.00	0	42.00
43.00	BEN LAZZARE CONSULTING	A	-160,000	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
45.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,475,715				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0251

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

Worksheet A-8-2

Date/Time Prepared:
7/28/2022 12:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	926,850	926,850	0	0	0	1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	215,750	215,750	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	406,250	406,250	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,522,536	1,522,536	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	32,393	32,393	0	0	0	5.00
6.00	91.00	AGGREGATE-EMERGENCY	4,246,908	4,246,908	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,350,687	7,350,687	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	926,850		1.00
2.00	34.00	AGGREGATE-SURGICAL INTENSIVE CARE UN	0	0	0	215,750		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	406,250		3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,522,536		4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	32,393		5.00
6.00	91.00	AGGREGATE-EMERGENCY	0	0	0	4,246,908		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	7,350,687		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,137,067	2,137,067			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,368,611		2,368,611		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,519,108	22,743	25,207	4,567,058	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,701,981	168,723	187,003	437,070	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,651,138	247,477	274,290	153,932	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	613,955	0	0	10,650	8.00
9.00	00900	HOUSEKEEPING	2,054,468	51,232	56,783	156,358	9.00
10.00	01000	DIETARY	1,299,026	68,110	75,490	76,233	10.00
11.00	01100	CAFETERIA	183,815	66,806	74,044	22,230	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,805,680	21,523	23,855	167,562	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	532,791	65,207	72,272	50,814	14.00
15.00	01500	PHARMACY	2,079,243	22,877	25,356	182,272	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,937,961	63,281	70,137	247,995	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 PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	238,433	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	9,025,705	461,135	511,100	820,117	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,330,405	61,573	68,244	349,852	34.00
44.00	04400	SKILLED NURSING FACILITY	3,000,378	167,528	185,679	210,488	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,681,378	176,220	195,312	219,549	50.00
51.00	05100	RECOVERY ROOM	475,197	11,813	13,093	45,032	51.00
53.00	05300	ANESTHESIOLOGY	61,236	5,175	5,735	5,710	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,661,368	84,618	93,786	145,544	54.00
56.00	05600	RADIOISOTOPE	307,094	5,175	5,735	18,945	56.00
57.00	05700	CT SCAN	678,670	9,407	10,426	54,588	57.00
58.00	05800	MRI	239,931	2,516	2,788	16,760	58.00
59.00	05900	CARDIAC CATHETERIZATION	866,319	51,619	57,212	86,274	59.00
60.00	06000	LABORATORY	5,211,992	81,109	89,897	203,403	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,610,978	17,089	18,940	110,660	65.00
66.00	06600	PHYSICAL THERAPY	948,284	40,942	45,378	89,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	474,798	10,349	11,470	45,060	67.00
68.00	06800	SPEECH PATHOLOGY	164,592	6,815	7,554	15,653	68.00
69.00	06900	ELECTROCARDIOLOGY	399,584	12,402	13,746	37,111	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,733	0	0	4,396	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,579,727	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,464,644	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,020,058	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	276,286	5,982	6,630	25,217	74.00
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	695,462	26,958	29,879	65,714	90.00
91.00	09100	EMERGENCY	4,459,827	88,589	98,188	464,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,803,923	2,124,993	2,355,229	4,539,803	87,751,212
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	12,074	13,382	0	25,456
194.00	07950	ADDISON CENTRAL PHARMACY	603,425	0	0	27,255	630,680
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	88,407,348	2,137,067	2,368,611	4,567,058	88,407,348

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,494,777					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,224,023	0	5,550,860			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	176,695	0	0	801,300		8.00
9.00	00900	HOUSEKEEPING	655,979	0	167,468	9,745	3,152,033	9.00
10.00	01000	DIETARY	429,672	0	222,639	0	130,358	10.00
11.00	01100	CAFETERIA	98,133	0	218,376	0	127,862	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	571,049	0	70,354	12,439	41,193	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	203,988	0	213,151	290	124,802	14.00
15.00	01500	PHARMACY	653,407	0	74,782	0	43,785	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	939,021	0	206,853	0	121,114	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	67,451	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,060,360	0	1,507,373	150,029	882,580	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,360,727	0	201,269	34,675	117,845	34.00
44.00	04400	SKILLED NURSING FACILITY	1,008,244	0	547,619	49,596	320,637	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	925,749	0	576,030	420,590	337,272	50.00
51.00	05100	RECOVERY ROOM	154,214	0	38,615	0	22,609	51.00
53.00	05300	ANESTHESIOLOGY	22,025	0	16,915	0	9,904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	561,628	0	276,601	17,694	161,953	54.00
56.00	05600	RADIOISOTOPE	95,320	0	16,915	0	9,904	56.00
57.00	05700	CT SCAN	213,043	0	30,749	0	18,004	57.00
58.00	05800	MRI	74,116	0	8,223	10,326	4,815	58.00
59.00	05900	CARDIAC CATHETERIZATION	300,267	0	168,733	42,439	98,795	59.00
60.00	06000	LABORATORY	1,580,343	0	265,132	2,403	155,238	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	497,228	0	55,859	0	32,706	65.00
66.00	06600	PHYSICAL THERAPY	318,138	0	133,831	7,500	78,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,236	0	33,829	0	19,807	67.00
68.00	06800	SPEECH PATHOLOGY	55,055	0	22,278	0	13,044	68.00
69.00	06900	ELECTROCARDIOLOGY	130,934	0	40,540	7,368	23,737	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,464	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	446,891	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	414,335	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,137,238	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	88,860	0	19,555	29,631	11,450	74.00
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	231,409	0	88,121	1,452	51,596	90.00
91.00	09100	EMERGENCY	1,445,920	0	289,583	5,123	169,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,309,162	0	5,511,393	801,300	3,128,924	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	7,201	0	39,467	0	23,109	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	178,414	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	19,494,777	0	5,550,860	801,300	3,152,033	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,301,528					10.00
11.00	01100	CAFETERIA	0	791,266				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,713,655		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,432	0	0	1,285,747	14.00
15.00	01500	PHARMACY	0	38,630	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,876	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 PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,366,993	180,227	0	1,102,906	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	282,944	67,315	0	453,329	0	34.00
44.00	04400	SKILLED NURSING FACILITY	651,591	50,264	0	278,602	11,522	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	45,736	0	216,784	0	50.00
51.00	05100	RECOVERY ROOM	0	7,489	0	58,140	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,759	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,042	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	3,396	0	0	0	56.00
57.00	05700	CT SCAN	0	14,020	0	13,510	0	57.00
58.00	05800	MRI	0	3,414	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,530	0	60,772	0	59.00
60.00	06000	LABORATORY	0	58,293	0	0	15,335	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	25,324	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,345	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,547	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,431	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,509	0	12,600	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,498	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	652,635	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	605,093	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,100	0	24,005	1,077	74.00
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	17,660	0	57,029	0	90.00
91.00	09100	EMERGENCY	0	100,824	0	435,978	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,301,528	787,661	0	2,713,655	1,285,662	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	3,605	0	0	85	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	2,301,528	791,266	0	2,713,655	1,285,747	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,120,352					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,639,238				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		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			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,953	706,646	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,510	202,738	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	2,382	127,018	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,193	163,856	0	0	0	50.00
51.00	05100	RECOVERY ROOM	724	30,824	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	180	61,487	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	191,098	0	0	0	54.00
56.00	05600	RADIOISOTOPE	31	33,342	0	0	0	56.00
57.00	05700	CT SCAN	1,843	374,515	0	0	0	57.00
58.00	05800	MRI	4	48,437	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	381	130,975	0	0	0	59.00
60.00	06000	LABORATORY	541	575,161	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	73	167,143	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	54,002	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,282	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,650	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12	141,241	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,238	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	143,424	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	53,804	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,889,058	725,374	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	660	18,348	0	0	0	74.00
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	216	83,488	0	0	0	90.00
91.00	09100	EMERGENCY	17,211	550,147	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,944,972	4,639,238	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	175,380	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	3,120,352	4,639,238	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2022 12:38 am

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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		305,884				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	19,791,124	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	7,539,426	0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	6,611,548	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,965,669	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	857,750	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	190,126	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,229,332	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	495,857	0	56.00
57.00	05700	CT SCAN	0	0	0	1,418,775	0	57.00
58.00	05800	MRI	0	0	0	411,330	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,875,316	0	59.00
60.00	06000	LABORATORY	0	0	0	8,238,847	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,536,000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,738,770	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	802,378	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	300,072	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	828,784	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	69,329	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,822,677	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,537,876	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,771,728	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	510,801	0	74.00
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	1,348,984	0	90.00
91.00	09100	EMERGENCY	0	305,884	0	8,431,452	-305,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	305,884	0	87,323,951	-305,884	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	95,233	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	988,164	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	0	305,884	0	88,407,348	-305,884	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING PROGRAM		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	19,791,124	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,539,426	34.00
44.00	04400	SKILLED NURSING FACILITY	6,611,548	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,965,669	50.00
51.00	05100	RECOVERY ROOM	857,750	51.00
53.00	05300	ANESTHESIOLOGY	190,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,229,332	54.00
56.00	05600	RADIOISOTOPE	495,857	56.00
57.00	05700	CT SCAN	1,418,775	57.00
58.00	05800	MRI	411,330	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,875,316	59.00
60.00	06000	LABORATORY	8,238,847	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,536,000	65.00
66.00	06600	PHYSICAL THERAPY	1,738,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,378	67.00
68.00	06800	SPEECH PATHOLOGY	300,072	68.00
69.00	06900	ELECTROCARDIOLOGY	828,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,822,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,537,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,771,728	73.00
74.00	07400	RENAL DIALYSIS	510,801	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,348,984	90.00
91.00	09100	EMERGENCY	8,125,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	93.99
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,018,067	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	95,233	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	988,164	194.00
194.01	07951	PHYSICIAN PRACTICES	0	194.01
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	88,101,464	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 12:38 am

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	22,743	25,207	47,950	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	168,723	187,003	355,726	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	247,477	274,290	521,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	51,232	56,783	108,015	9.00
10.00	01000	DIETARY	0	68,110	75,490	143,600	10.00
11.00	01100	CAFETERIA	0	66,806	74,044	140,850	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	21,523	23,855	45,378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	65,207	72,272	137,479	14.00
15.00	01500	PHARMACY	0	22,877	25,356	48,233	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,281	70,137	133,418	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 PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	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	461,135	511,100	972,235	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	61,573	68,244	129,817	34.00
44.00	04400	SKILLED NURSING FACILITY	0	167,528	185,679	353,207	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	176,220	195,312	371,532	50.00
51.00	05100	RECOVERY ROOM	0	11,813	13,093	24,906	51.00
53.00	05300	ANESTHESIOLOGY	0	5,175	5,735	10,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,618	93,786	178,404	54.00
56.00	05600	RADIOISOTOPE	0	5,175	5,735	10,910	56.00
57.00	05700	CT SCAN	0	9,407	10,426	19,833	57.00
58.00	05800	MRI	0	2,516	2,788	5,304	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	51,619	57,212	108,831	59.00
60.00	06000	LABORATORY	0	81,109	89,897	171,006	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	17,089	18,940	36,029	65.00
66.00	06600	PHYSICAL THERAPY	0	40,942	45,378	86,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,349	11,470	21,819	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,815	7,554	14,369	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,402	13,746	26,148	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	5,982	6,630	12,612	74.00
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	26,958	29,879	56,837	90.00
91.00	09100	EMERGENCY	0	88,589	98,188	186,777	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,124,993	2,355,229	4,480,222	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	12,074	13,382	25,456	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,137,067	2,368,611	4,505,678	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	360,314					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	22,625	0	546,008			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,266	0	0	3,378		8.00
9.00	00900	HOUSEKEEPING	12,125	0	16,473	41	138,295	9.00
10.00	01000	DIETARY	7,942	0	21,900	0	5,719	10.00
11.00	01100	CAFETERIA	1,814	0	21,481	0	5,610	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,555	0	6,920	52	1,807	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,771	0	20,966	1	5,476	14.00
15.00	01500	PHARMACY	12,078	0	7,356	0	1,921	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,357	0	20,347	0	5,314	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,247	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,536	0	148,270	632	38,723	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	25,152	0	19,798	146	5,170	34.00
44.00	04400	SKILLED NURSING FACILITY	18,637	0	53,866	209	14,068	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,112	0	56,661	1,773	14,798	50.00
51.00	05100	RECOVERY ROOM	2,851	0	3,798	0	992	51.00
53.00	05300	ANESTHESIOLOGY	407	0	1,664	0	435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,381	0	27,208	75	7,106	54.00
56.00	05600	RADIOISOTOPE	1,762	0	1,664	0	435	56.00
57.00	05700	CT SCAN	3,938	0	3,025	0	790	57.00
58.00	05800	MRI	1,370	0	809	44	211	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,550	0	16,597	179	4,335	59.00
60.00	06000	LABORATORY	29,211	0	26,080	10	6,811	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	9,191	0	5,495	0	1,435	65.00
66.00	06600	PHYSICAL THERAPY	5,881	0	13,164	32	3,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,832	0	3,328	0	869	67.00
68.00	06800	SPEECH PATHOLOGY	1,018	0	2,191	0	572	68.00
69.00	06900	ELECTROCARDIOLOGY	2,420	0	3,988	31	1,041	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	267	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,260	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,659	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,021	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,643	0	1,924	125	502	74.00
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	4,277	0	8,668	6	2,264	90.00
91.00	09100	EMERGENCY	26,727	0	28,485	22	7,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,883	0	542,126	3,378	137,281	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	133	0	3,882	0	1,014	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	3,298	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	360,314	0	546,008	3,378	138,295	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	179,961					10.00
11.00	01100	CAFETERIA	0	169,988				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	66,471		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,819	0	0	173,045	14.00
15.00	01500	PHARMACY	0	8,299	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,359	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 PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	106,888	38,719	0	27,016	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	22,124	14,461	0	11,104	0	34.00
44.00	04400	SKILLED NURSING FACILITY	50,949	10,798	0	6,824	1,551	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,825	0	5,310	0	50.00
51.00	05100	RECOVERY ROOM	0	1,609	0	1,424	0	51.00
53.00	05300	ANESTHESIOLOGY	0	378	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,528	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	730	0	0	0	56.00
57.00	05700	CT SCAN	0	3,012	0	331	0	57.00
58.00	05800	MRI	0	733	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,477	0	1,489	0	59.00
60.00	06000	LABORATORY	0	12,523	0	0	2,064	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,440	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,800	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,481	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	737	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,043	0	309	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	322	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	87,837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	81,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	666	0	588	145	74.00
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	3,794	0	1,397	0	90.00
91.00	09100	EMERGENCY	0	21,660	0	10,679	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179,961	169,213	0	66,471	173,034	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	775	0	0	11	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	179,961	169,988	0	66,471	173,045	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	79,800					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	190,398				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			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	408	28,994	0			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	218	8,318	0			34.00
44.00	04400	SKILLED NURSING FACILITY	61	5,212	0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	184	6,723	0			50.00
51.00	05100	RECOVERY ROOM	19	1,265	0			51.00
53.00	05300	ANESTHESIOLOGY	5	2,523	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,841	0			54.00
56.00	05600	RADIOISOTOPE	1	1,368	0			56.00
57.00	05700	CT SCAN	47	15,367	0			57.00
58.00	05800	MRI	0	1,987	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	10	5,374	0			59.00
60.00	06000	LABORATORY	14	23,599	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	2	6,858	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,216	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,735	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	478	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,795	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	92	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,885	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,208	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,883	29,808	0			73.00
74.00	07400	RENAL DIALYSIS	17	753	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6	3,426	0			90.00
91.00	09100	EMERGENCY	440	22,573	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,315	190,398	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
194.00	07950	ADDISON CENTRAL PHARMACY	4,485	0	0			194.00
194.01	07951	PHYSICIAN PRACTICES	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)	79,800	190,398	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 12:38 am

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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,247				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,427,038	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				239,980	0	34.00
44.00	04400	SKILLED NURSING FACILITY				517,592	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				486,223	0	50.00
51.00	05100	RECOVERY ROOM				37,337	0	51.00
53.00	05300	ANESTHESIOLOGY				16,382	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				240,071	0	54.00
56.00	05600	RADIOISOTOPE				17,069	0	56.00
57.00	05700	CT SCAN				46,916	0	57.00
58.00	05800	MRI				10,634	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				145,748	0	59.00
60.00	06000	LABORATORY				273,453	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				65,612	0	65.00
66.00	06600	PHYSICAL THERAPY				116,796	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				33,537	0	67.00
68.00	06800	SPEECH PATHOLOGY				19,529	0	68.00
69.00	06900	ELECTROCARDIOLOGY				42,165	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				727	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				101,982	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				91,304	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				124,712	0	73.00
74.00	07400	RENAL DIALYSIS				19,240	0	74.00
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				81,365	0	90.00
91.00	09100	EMERGENCY				309,679	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	4,465,091	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				30,485	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY				8,855	0	194.00
194.01	07951	PHYSICIAN PRACTICES				0	0	194.01
200.00		Cross Foot Adjustments	0	1,247	0	1,247	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,247	0	4,505,678	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING PROGRAM	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	34.00
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
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	194.00
194.01	07951	PHYSICIAN PRACTICES	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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	253,994					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		253,994				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,703	2,703	44,554,626			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,053	20,053	4,263,885	-19,494,777	68,912,571	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	29,413	29,413	1,501,703	0	4,326,837	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	103,899	0	624,605	8.00
9.00	00900	HOUSEKEEPING	6,089	6,089	1,525,373	0	2,318,841	9.00
10.00	01000	DIETARY	8,095	8,095	743,698	0	1,518,859	10.00
11.00	01100	CAFETERIA	7,940	7,940	216,863	0	346,895	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,558	2,558	1,634,674	0	2,018,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,750	7,750	495,723	0	721,084	14.00
15.00	01500	PHARMACY	2,719	2,719	1,778,172	0	2,309,748	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,521	7,521	2,419,346	0	3,319,374	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	238,433	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	54,807	54,807	8,000,902	0	10,818,057	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,318	7,318	3,413,021	0	4,810,074	34.00
44.00	04400	SKILLED NURSING FACILITY	19,911	19,911	2,053,445	0	3,564,073	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,944	20,944	2,141,836	0	3,272,459	50.00
51.00	05100	RECOVERY ROOM	1,404	1,404	439,311	0	545,135	51.00
53.00	05300	ANESTHESIOLOGY	615	615	55,702	0	77,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,057	10,057	1,419,875	0	1,985,316	54.00
56.00	05600	RADIOISOTOPE	615	615	184,816	0	336,949	56.00
57.00	05700	CT SCAN	1,118	1,118	532,538	0	753,091	57.00
58.00	05800	MRI	299	299	163,502	0	261,995	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,135	6,135	841,653	0	1,061,424	59.00
60.00	06000	LABORATORY	9,640	9,640	1,984,319	0	5,586,401	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,031	2,031	1,079,561	0	1,757,667	65.00
66.00	06600	PHYSICAL THERAPY	4,866	4,866	877,909	0	1,124,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,230	1,230	439,589	0	541,677	67.00
68.00	06800	SPEECH PATHOLOGY	810	810	152,707	0	194,614	68.00
69.00	06900	ELECTROCARDIOLOGY	1,474	1,474	362,044	0	462,843	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	42,886	0	51,129	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,579,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,464,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,020,058	73.00
74.00	07400	RENAL DIALYSIS	711	711	246,012	0	314,115	74.00
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	3,204	3,204	641,078	0	818,013	90.00
91.00	09100	EMERGENCY	10,529	10,529	4,532,696	0	5,111,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	252,559	252,559	44,288,738	-19,494,777	68,256,435	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,435	1,435	0	0	25,456	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	265,888	0	630,680	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	2,137,067	2,368,611	4,567,058		19,494,777	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.413848	9.325460	0.102505		0.282891	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			47,950		360,314	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001076		0.005229	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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	201,825				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	30,342			8.00
9.00	00900	HOUSEKEEPING	0	6,089	369	195,736		9.00
10.00	01000	DIETARY	0	8,095	0	8,095	103,443	10.00
11.00	01100	CAFETERIA	0	7,940	0	7,940	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,558	471	2,558	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,750	11	7,750	0	14.00
15.00	01500	PHARMACY	0	2,719	0	2,719	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,521	0	7,521	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 PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	54,807	5,681	54,807	61,440	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	7,318	1,313	7,318	12,717	34.00
44.00	04400	SKILLED NURSING FACILITY	0	19,911	1,878	19,911	29,286	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,944	15,926	20,944	0	50.00
51.00	05100	RECOVERY ROOM	0	1,404	0	1,404	0	51.00
53.00	05300	ANESTHESIOLOGY	0	615	0	615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,057	670	10,057	0	54.00
56.00	05600	RADIOISOTOPE	0	615	0	615	0	56.00
57.00	05700	CT SCAN	0	1,118	0	1,118	0	57.00
58.00	05800	MRI	0	299	391	299	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,135	1,607	6,135	0	59.00
60.00	06000	LABORATORY	0	9,640	91	9,640	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,031	0	2,031	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,866	284	4,866	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,230	0	1,230	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	810	0	810	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,474	279	1,474	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	711	1,122	711	0	74.00
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	3,204	55	3,204	0	90.00
91.00	09100	EMERGENCY	0	10,529	194	10,529	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	200,390	30,342	194,301	103,443	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,435	0	1,435	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	0	5,550,860	801,300	3,152,033	2,301,528	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.503332	26.408938	16.103491	22.249239	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	546,008	3,378	138,295	179,961	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.705354	0.111331	0.706538	1.739712	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	45,432					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	417,594			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,288	0	0	3,112,190		14.00
15.00	01500	PHARMACY	2,218	0	0	0	4,341,898	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,036	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 PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,348	0	169,722	0	22,198	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,865	0	69,761	0	11,841	34.00
44.00	04400	SKILLED NURSING FACILITY	2,886	0	42,873	27,890	3,314	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,626	0	33,360	0	10,009	50.00
51.00	05100	RECOVERY ROOM	430	0	8,947	0	1,007	51.00
53.00	05300	ANESTHESIOLOGY	101	0	0	0	251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,012	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	195	0	0	0	43	56.00
57.00	05700	CT SCAN	805	0	2,079	0	2,564	57.00
58.00	05800	MRI	196	0	0	0	6	58.00
59.00	05900	CARDIAC CATHETERIZATION	662	0	9,352	0	530	59.00
60.00	06000	LABORATORY	3,347	0	0	37,118	753	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,454	0	0	0	102	65.00
66.00	06600	PHYSICAL THERAPY	1,283	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	663	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	197	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	546	0	1,939	0	17	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,579,727	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,464,644	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,020,058	73.00
74.00	07400	RENAL DIALYSIS	178	0	3,694	2,606	919	74.00
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	1,014	0	8,776	0	300	90.00
91.00	09100	EMERGENCY	5,789	0	67,091	0	23,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		45,225	0	417,594	3,111,985	4,097,861	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	207	0	0	205	244,037	194.00
194.01	07951	PHYSICIAN PRACTICES	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)		791,266	0	2,713,655	1,285,747	3,120,352	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		17.416491	0.000000	6.498309	0.413133	0.718661	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		169,988	0	66,471	173,045	79,800	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		3.741592	0.000000	0.159176	0.055602	0.018379	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
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: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	442,694,111					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	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	67,428,059	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	19,345,275	0	0	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	12,120,055	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,635,098	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	2,941,213	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,867,093	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,234,533	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	3,181,450	0	0	0	0	56.00
57.00	05700	CT SCAN	35,736,203	0	0	0	0	57.00
58.00	05800	MRI	4,621,847	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,497,584	0	0	0	0	59.00
60.00	06000	LABORATORY	54,881,789	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	15,948,738	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,152,816	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,034,570	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,111,682	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,477,160	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	213,546	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,685,527	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,134,011	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,233,722	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,750,811	0	0	0	0	74.00
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	7,966,376	0	0	0	0	90.00
91.00	09100	EMERGENCY	52,494,953	0	0	0	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	442,694,111	0	0	0	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	4,639,238	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010480	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	190,398	0	0	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000430	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet B-1
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS APPRV (ASSIGNED TIME)		
			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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	100		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
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	100	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ADDISON CENTRAL PHARMACY	0	0	194.00
194.01	07951	PHYSICIAN PRACTICES	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)	305,884	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,058.840000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,247	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0251

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

Worksheet B-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	12.470000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 12:38 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,791,124		19,791,124	0	19,791,124	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,539,426		7,539,426	0	7,539,426	34.00
44.00	04400	SKILLED NURSING FACILITY	6,611,548		6,611,548	0	6,611,548	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,965,669		5,965,669	0	5,965,669	50.00
51.00	05100	RECOVERY ROOM	857,750		857,750	0	857,750	51.00
53.00	05300	ANESTHESIOLOGY	190,126		190,126	0	190,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,229,332		3,229,332	0	3,229,332	54.00
56.00	05600	RADIOISOTOPE	495,857		495,857	0	495,857	56.00
57.00	05700	CT SCAN	1,418,775		1,418,775	0	1,418,775	57.00
58.00	05800	MRI	411,330		411,330	0	411,330	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,875,316		1,875,316	0	1,875,316	59.00
60.00	06000	LABORATORY	8,238,847		8,238,847	0	8,238,847	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,536,000	0	2,536,000	0	2,536,000	65.00
66.00	06600	PHYSICAL THERAPY	1,738,770	0	1,738,770	0	1,738,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,378	0	802,378	0	802,378	67.00
68.00	06800	SPEECH PATHOLOGY	300,072	0	300,072	0	300,072	68.00
69.00	06900	ELECTROCARDIOLOGY	828,784		828,784	0	828,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,329		69,329	0	69,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,822,677		2,822,677	0	2,822,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,537,876		2,537,876	0	2,537,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,771,728		8,771,728	0	8,771,728	73.00
74.00	07400	RENAL DIALYSIS	510,801		510,801	0	510,801	74.00
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	1,348,984		1,348,984	0	1,348,984	90.00
91.00	09100	EMERGENCY	8,125,568		8,125,568	0	8,125,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,160,376		2,160,376	0	2,160,376	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	89,178,443	0	89,178,443	0	89,178,443	200.00
201.00		Less Observation Beds	2,160,376		2,160,376	0	2,160,376	201.00
202.00		Total (see instructions)	87,018,067	0	87,018,067	0	87,018,067	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0251		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 7/28/2022 12:38 am		
				Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	60,953,779		60,953,779				30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	19,345,275		19,345,275				34.00	
44.00	04400	SKILLED NURSING FACILITY	12,120,055		12,120,055				44.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	7,433,127	8,201,971	15,635,098	0.381556	0.000000		50.00	
51.00	05100	RECOVERY ROOM	1,544,740	1,396,473	2,941,213	0.291631	0.000000		51.00	
53.00	05300	ANESTHESIOLOGY	2,373,980	3,493,113	5,867,093	0.032405	0.000000		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,427,441	10,807,092	18,234,533	0.177100	0.000000		54.00	
56.00	05600	RADIOISOTOPE	1,217,464	1,963,986	3,181,450	0.155859	0.000000		56.00	
57.00	05700	CT SCAN	13,424,310	22,311,893	35,736,203	0.039701	0.000000		57.00	
58.00	05800	MRI	2,105,755	2,516,092	4,621,847	0.088997	0.000000		58.00	
59.00	05900	CARDIAC CATHETERIZATION	10,092,109	2,405,475	12,497,584	0.150054	0.000000		59.00	
60.00	06000	LABORATORY	38,470,656	16,411,133	54,881,789	0.150120	0.000000		60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30	
65.00	06500	RESPIRATORY THERAPY	15,354,077	594,661	15,948,738	0.159009	0.000000		65.00	
66.00	06600	PHYSICAL THERAPY	4,161,832	990,984	5,152,816	0.337441	0.000000		66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,504,801	529,769	4,034,570	0.198876	0.000000		67.00	
68.00	06800	SPEECH PATHOLOGY	1,056,403	55,279	1,111,682	0.269926	0.000000		68.00	
69.00	06900	ELECTROCARDIOLOGY	7,801,073	5,676,087	13,477,160	0.061495	0.000000		69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	152,632	60,914	213,546	0.324656	0.000000		70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,991,549	2,693,978	13,685,527	0.206253	0.000000		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,312,516	1,821,495	5,134,011	0.494326	0.000000		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	61,092,399	8,141,323	69,233,722	0.126697	0.000000		73.00	
74.00	07400	RENAL DIALYSIS	1,670,795	80,016	1,750,811	0.291751	0.000000		74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99	
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	1,458,896	6,507,480	7,966,376	0.169335	0.000000		90.00	
91.00	09100	EMERGENCY	17,025,693	35,469,260	52,494,953	0.154788	0.000000		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,225,708	5,248,572	6,474,280	0.333686	0.000000		92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000		93.99	
200.00		Subtotal (see instructions)	305,317,065	137,377,046	442,694,111				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	305,317,065	137,377,046	442,694,111				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.381556			50.00
51.00	05100	RECOVERY ROOM	0.291631			51.00
53.00	05300	ANESTHESIOLOGY	0.032405			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100			54.00
56.00	05600	RADIOISOTOPE	0.155859			56.00
57.00	05700	CT SCAN	0.039701			57.00
58.00	05800	MRI	0.088997			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.150054			59.00
60.00	06000	LABORATORY	0.150120			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.159009			65.00
66.00	06600	PHYSICAL THERAPY	0.337441			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198876			67.00
68.00	06800	SPEECH PATHOLOGY	0.269926			68.00
69.00	06900	ELECTROCARDIOLOGY	0.061495			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.324656			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206253			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494326			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126697			73.00
74.00	07400	RENAL DIALYSIS	0.291751			74.00
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	0.169335			90.00
91.00	09100	EMERGENCY	0.154788			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333686			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 12:38 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,791,124		19,791,124	0	19,791,124	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,539,426		7,539,426	0	7,539,426	34.00
44.00	04400	SKILLED NURSING FACILITY	6,611,548		6,611,548	0	6,611,548	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,965,669		5,965,669	0	5,965,669	50.00
51.00	05100	RECOVERY ROOM	857,750		857,750	0	857,750	51.00
53.00	05300	ANESTHESIOLOGY	190,126		190,126	0	190,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,229,332		3,229,332	0	3,229,332	54.00
56.00	05600	RADIOISOTOPE	495,857		495,857	0	495,857	56.00
57.00	05700	CT SCAN	1,418,775		1,418,775	0	1,418,775	57.00
58.00	05800	MRI	411,330		411,330	0	411,330	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,875,316		1,875,316	0	1,875,316	59.00
60.00	06000	LABORATORY	8,238,847		8,238,847	0	8,238,847	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,536,000	0	2,536,000	0	2,536,000	65.00
66.00	06600	PHYSICAL THERAPY	1,738,770	0	1,738,770	0	1,738,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,378	0	802,378	0	802,378	67.00
68.00	06800	SPEECH PATHOLOGY	300,072	0	300,072	0	300,072	68.00
69.00	06900	ELECTROCARDIOLOGY	828,784		828,784	0	828,784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,329		69,329	0	69,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,822,677		2,822,677	0	2,822,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,537,876		2,537,876	0	2,537,876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,771,728		8,771,728	0	8,771,728	73.00
74.00	07400	RENAL DIALYSIS	510,801		510,801	0	510,801	74.00
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	1,348,984		1,348,984	0	1,348,984	90.00
91.00	09100	EMERGENCY	8,125,568		8,125,568	0	8,125,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,160,376		2,160,376	0	2,160,376	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	89,178,443	0	89,178,443	0	89,178,443	200.00
201.00		Less Observation Beds	2,160,376		2,160,376	0	2,160,376	201.00
202.00		Total (see instructions)	87,018,067	0	87,018,067	0	87,018,067	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 12:38 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	60,953,779		60,953,779		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	19,345,275		19,345,275		34.00
44.00	04400	SKILLED NURSING FACILITY	12,120,055		12,120,055		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,433,127	8,201,971	15,635,098	0.381556	50.00
51.00	05100	RECOVERY ROOM	1,544,740	1,396,473	2,941,213	0.291631	51.00
53.00	05300	ANESTHESIOLOGY	2,373,980	3,493,113	5,867,093	0.032405	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,427,441	10,807,092	18,234,533	0.177100	54.00
56.00	05600	RADIOISOTOPE	1,217,464	1,963,986	3,181,450	0.155859	56.00
57.00	05700	CT SCAN	13,424,310	22,311,893	35,736,203	0.039701	57.00
58.00	05800	MRI	2,105,755	2,516,092	4,621,847	0.088997	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,092,109	2,405,475	12,497,584	0.150054	59.00
60.00	06000	LABORATORY	38,470,656	16,411,133	54,881,789	0.150120	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	15,354,077	594,661	15,948,738	0.159009	65.00
66.00	06600	PHYSICAL THERAPY	4,161,832	990,984	5,152,816	0.337441	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,504,801	529,769	4,034,570	0.198876	67.00
68.00	06800	SPEECH PATHOLOGY	1,056,403	55,279	1,111,682	0.269926	68.00
69.00	06900	ELECTROCARDIOLOGY	7,801,073	5,676,087	13,477,160	0.061495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152,632	60,914	213,546	0.324656	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,991,549	2,693,978	13,685,527	0.206253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,312,516	1,821,495	5,134,011	0.494326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,092,399	8,141,323	69,233,722	0.126697	73.00
74.00	07400	RENAL DIALYSIS	1,670,795	80,016	1,750,811	0.291751	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	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	1,458,896	6,507,480	7,966,376	0.169335	90.00
91.00	09100	EMERGENCY	17,025,693	35,469,260	52,494,953	0.154788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,225,708	5,248,572	6,474,280	0.333686	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	93.99
200.00		Subtotal (see instructions)	305,317,065	137,377,046	442,694,111		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	305,317,065	137,377,046	442,694,111		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
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
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
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
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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
76.97	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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
7/28/2022 12:38 am

Title XVIII			Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,427,038	0	1,427,038	22,939	62.21	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	239,980		239,980	4,239	56.61	34.00
44.00	SKILLED NURSING FACILITY	517,592		517,592	9,762	53.02	44.00
200.00	Total (lines 30 through 199)	2,184,610		2,184,610	36,940		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	7,146	444,553				
34.00	SURGICAL INTENSIVE CARE UNIT	1,589	89,953				
44.00	SKILLED NURSING FACILITY	6,921	366,951				
200.00	Total (lines 30 through 199)	15,656	901,457				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
7/28/2022 12:38 am

			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	486,223	15,635,098	0.031098	2,282,469	70,980	50.00
51.00	05100	RECOVERY ROOM	37,337	2,941,213	0.012694	445,391	5,654	51.00
53.00	05300	ANESTHESIOLOGY	16,382	5,867,093	0.002792	778,802	2,174	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,071	18,234,533	0.013166	2,338,854	30,793	54.00
56.00	05600	RADIOISOTOPE	17,069	3,181,450	0.005365	411,584	2,208	56.00
57.00	05700	CT SCAN	46,916	35,736,203	0.001313	4,649,604	6,105	57.00
58.00	05800	MRI	10,634	4,621,847	0.002301	675,335	1,554	58.00
59.00	05900	CARDIAC CATHETERIZATION	145,748	12,497,584	0.011662	2,798,653	32,638	59.00
60.00	06000	LABORATORY	273,453	54,881,789	0.004983	11,954,954	59,572	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	65,612	15,948,738	0.004114	4,912,104	20,208	65.00
66.00	06600	PHYSICAL THERAPY	116,796	5,152,816	0.022666	354,791	8,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,537	4,034,570	0.008312	316,620	2,632	67.00
68.00	06800	SPEECH PATHOLOGY	19,529	1,111,682	0.017567	328,384	5,769	68.00
69.00	06900	ELECTROCARDIOLOGY	42,165	13,477,160	0.003129	3,519,510	11,013	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	727	213,546	0.003404	67,070	228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,982	13,685,527	0.007452	3,624,166	27,007	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	91,304	5,134,011	0.017784	1,226,511	21,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,712	69,233,722	0.001801	17,582,825	31,667	73.00
74.00	07400	RENAL DIALYSIS	19,240	1,750,811	0.010989	736,958	8,098	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	81,365	7,966,376	0.010214	535,811	5,473	90.00
91.00	09100	EMERGENCY	309,679	52,494,953	0.005899	5,878,028	34,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	155,774	6,474,280	0.024060	446,949	10,754	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	2,436,255	350,275,002		65,865,373	399,055	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0251		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 7/28/2022 12:38 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00	
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	22,939	0.00	7,146	0	30.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	4,239	0.00	1,589	0	34.00	
44.00	04400	SKILLED NURSING FACILITY		0	9,762	0.00	6,921	0	44.00	
200.00		Total (lines 30 through 199)		0	36,940		15,656	0	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0							34.00
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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
200.00	Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0251		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 7/28/2022 12:38 am	
				Title XVIII		Hospital	PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
				4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	15,635,098	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	0	2,941,213	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	5,867,093	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	18,234,533	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0	3,181,450	0.000000
57.00	05700	CT SCAN	0	0	0	0	35,736,203	0.000000
58.00	05800	MRI	0	0	0	0	4,621,847	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	12,497,584	0.000000
60.00	06000	LABORATORY	0	0	0	0	54,881,789	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	15,948,738	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,152,816	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,034,570	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,111,682	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	13,477,160	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	213,546	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,685,527	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,134,011	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	69,233,722	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,750,811	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	7,966,376	0.000000
91.00	09100	EMERGENCY	0	0	0	0	52,494,953	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	6,474,280	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	0	350,275,002	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	2,282,469	0	1,528,435	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	445,391	0	231,981	0	51.00	
53.00	05300 ANESTHESIOLOGY	0.000000	778,802	0	676,397	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,338,854	0	1,298,673	0	54.00	
56.00	05600 RADIOISOTOPE	0.000000	411,584	0	497,529	0	56.00	
57.00	05700 CT SCAN	0.000000	4,649,604	0	3,956,239	0	57.00	
58.00	05800 MRI	0.000000	675,335	0	766,239	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	2,798,653	0	607,796	0	59.00	
60.00	06000 LABORATORY	0.000000	11,954,954	0	2,039,083	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	4,912,104	0	94,255	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	354,791	0	3,510	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	316,620	0	3,639	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	328,384	0	9,465	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,519,510	0	1,472,151	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	67,070	0	14,842	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,624,166	0	538,589	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,226,511	0	371,090	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	17,582,825	0	1,650,122	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	736,958	0	24,902	0	74.00	
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	535,811	0	1,387,601	0	90.00	
91.00	09100 EMERGENCY	0.000000	5,878,028	0	4,528,471	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	446,949	0	1,052,223	0	92.00	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00	Total (lines 50 through 199)		65,865,373	0	22,753,232	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
7/28/2022 12:38 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.381556	1,528,435	0	0	583,184	50.00
51.00	05100	RECOVERY ROOM	0.291631	231,981	0	0	67,653	51.00
53.00	05300	ANESTHESIOLOGY	0.032405	676,397	0	0	21,919	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	1,298,673	0	0	229,995	54.00
56.00	05600	RADIOISOTOPE	0.155859	497,529	0	0	77,544	56.00
57.00	05700	CT SCAN	0.039701	3,956,239	0	0	157,067	57.00
58.00	05800	MRI	0.088997	766,239	0	0	68,193	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.150054	607,796	0	0	91,202	59.00
60.00	06000	LABORATORY	0.150120	2,039,083	11,890	0	306,107	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.159009	94,255	0	0	14,987	65.00
66.00	06600	PHYSICAL THERAPY	0.337441	3,510	0	0	1,184	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198876	3,639	0	0	724	67.00
68.00	06800	SPEECH PATHOLOGY	0.269926	9,465	0	0	2,555	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061495	1,472,151	0	0	90,530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.324656	14,842	0	0	4,819	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206253	538,589	0	0	111,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494326	371,090	0	0	183,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126697	1,650,122	1,077	1,996	209,066	73.00
74.00	07400	RENAL DIALYSIS	0.291751	24,902	0	0	7,265	74.00
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	0.169335	1,387,601	0	0	234,969	90.00
91.00	09100	EMERGENCY	0.154788	4,528,471	0	0	700,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333686	1,052,223	0	0	351,112	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		22,753,232	12,967	1,996	3,515,553	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		22,753,232	12,967	1,996	3,515,553	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 7/28/2022 12:38 am
	Title XVIII	Hospital	PPS

	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	1,785	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	136	253		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	1,921	253		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,921	253		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:

Worksheet D

Component CCN: 14-5548

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
7/28/2022 12:38 am

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	0.381556	0	0	0	0 50.00
51.00	05100 RECOVERY ROOM	0.291631	0	0	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.032405	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.177100	0	0	0	0 54.00
56.00	05600 RADIOISOTOPE	0.155859	0	0	0	0 56.00
57.00	05700 CT SCAN	0.039701	0	0	0	0 57.00
58.00	05800 MRI	0.088997	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.150054	0	0	0	0 59.00
60.00	06000 LABORATORY	0.150120	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.159009	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.337441	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.198876	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.269926	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.061495	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.324656	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.206253	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.494326	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.126697	0	0	1,114	0 73.00
74.00	07400 RENAL DIALYSIS	0.291751	0	0	0	0 74.00
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	0.169335	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.154788	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.333686	0	0	0	0 92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
200.00	Subtotal (see instructions)		0	0	1,114	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	1,114	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0251

Period:

Worksheet D

Component CCN: 14-5548

From 01/01/2021
To 12/31/2021Part V
Date/Time Prepared:
7/28/2022 12:38 am

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	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
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	141	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	141	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	141	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 12:38 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			22,939	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			22,939	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)			20,435	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)			7,146	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)			19,791,124	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)			19,791,124	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)			19,791,124	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)			862.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,165,354	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			6,165,354	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 12:38 am

			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)						42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	7,539,426	4,239	1,778.59	1,589	2,826,180	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)						10,200,516	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						19,192,050	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)						534,506	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						399,055	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						933,561	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						18,258,489	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						2,504	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						862.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,160,376	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 12:38 am

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,427,038	19,791,124	0.072105	2,160,376	155,774	90.00
91.00 Nursing Program cost	0	19,791,124	0.000000	2,160,376	0	91.00
92.00 Allied health cost	0	19,791,124	0.000000	2,160,376	0	92.00
93.00 All other Medical Education	0	19,791,124	0.000000	2,160,376	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 12:38 am
		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)		9,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,762	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)		9,762	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		6,921	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)		6,611,548	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)		6,611,548	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)		6,611,548	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: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-5548		Date/Time Prepared: 7/28/2022 12:38 am	
				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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)						6,611,548 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						677.27 71.00
72.00	Program routine service cost (line 9 x line 71)						4,687,386 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						4,687,386 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						4,687,386 83.00
84.00	Program inpatient ancillary services (see instructions)						2,513,102 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						7,200,488 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

Period:

Worksheet D-1

Component CCN: 14-5548

From 01/01/2021
To 12/31/2021Date/Time Prepared:
7/28/2022 12:38 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program 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: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 7/28/2022 12:38 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,939	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,939	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)		20,435	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)		2,394	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)		19,791,124	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)		19,791,124	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)		19,791,124	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)		862.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,065,471	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,065,471	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Title XIX		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,539,426	4,239	1,778.59	503	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,389,952 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,350,054 49.00
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					2,504 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					862.77 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,160,376 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0251

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

Worksheet D-1

Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,427,038	19,791,124	0.072105	2,160,376	155,774	90.00
91.00	Nursing Program cost	0	19,791,124	0.000000	2,160,376	0	91.00
92.00	Allied health cost	0	19,791,124	0.000000	2,160,376	0	92.00
93.00	All other Medical Education	0	19,791,124	0.000000	2,160,376	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/28/2022 12:38 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		20,560,747		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		6,498,978		34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.381556	2,282,469	870,890	50.00
51.00	05100	RECOVERY ROOM	0.291631	445,391	129,890	51.00
53.00	05300	ANESTHESIOLOGY	0.032405	778,802	25,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	2,338,854	414,211	54.00
56.00	05600	RADIOISOTOPE	0.155859	411,584	64,149	56.00
57.00	05700	CT SCAN	0.039701	4,649,604	184,594	57.00
58.00	05800	MRI	0.088997	675,335	60,103	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.150054	2,798,653	419,949	59.00
60.00	06000	LABORATORY	0.150120	11,954,954	1,794,678	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.159009	4,912,104	781,069	65.00
66.00	06600	PHYSICAL THERAPY	0.337441	354,791	119,721	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198876	316,620	62,968	67.00
68.00	06800	SPEECH PATHOLOGY	0.269926	328,384	88,639	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061495	3,519,510	216,432	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.324656	67,070	21,775	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206253	3,624,166	747,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494326	1,226,511	606,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126697	17,582,825	2,227,691	73.00
74.00	07400	RENAL DIALYSIS	0.291751	736,958	215,008	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.169335	535,811	90,732	90.00
91.00	09100	EMERGENCY	0.154788	5,878,028	909,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333686	446,949	149,141	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		65,865,373	10,200,516	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)		65,865,373		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/28/2022 12:38 am	
		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
34.00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.381556	8,923	3,405	50.00
51.00	05100 RECOVERY ROOM	0.291631	4,231	1,234	51.00
53.00	05300 ANESTHESIOLOGY	0.032405	1,579	51	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.177100	174,365	30,880	54.00
56.00	05600 RADIOISOTOPE	0.155859	6,771	1,055	56.00
57.00	05700 CT SCAN	0.039701	8,987	357	57.00
58.00	05800 MRI	0.088997	41,101	3,658	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.150054	24,233	3,636	59.00
60.00	06000 LABORATORY	0.150120	2,468,781	370,613	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.159009	1,036,992	164,891	65.00
66.00	06600 PHYSICAL THERAPY	0.337441	2,216,950	748,090	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.198876	1,910,623	379,977	67.00
68.00	06800 SPEECH PATHOLOGY	0.269926	169,887	45,857	68.00
69.00	06900 ELECTROCARDIOLOGY	0.061495	30,531	1,878	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.324656	1,228	399	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.206253	746,886	154,047	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.494326	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.126697	4,744,061	601,058	73.00
74.00	07400 RENAL DIALYSIS	0.291751	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.169335	2,585	438	90.00
91.00	09100 EMERGENCY	0.154788	10,196	1,578	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.333686	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		13,608,910	2,513,102	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		13,608,910		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 7/28/2022 12:38 am	
			Title XIX	Hospital	Cost	
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		6,594,781		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		2,006,912		34.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.381556	1,437,140	548,349	50.00
51.00	05100	RECOVERY ROOM	0.291631	206,671	60,272	51.00
53.00	05300	ANESTHESIOLOGY	0.032405	353,490	11,455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	511,514	90,589	54.00
56.00	05600	RADIOISOTOPE	0.155859	146,294	22,801	56.00
57.00	05700	CT SCAN	0.039701	1,571,931	62,407	57.00
58.00	05800	MRI	0.088997	231,695	20,620	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.150054	746,291	111,984	59.00
60.00	06000	LABORATORY	0.150120	4,110,885	617,126	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.159009	1,461,747	232,431	65.00
66.00	06600	PHYSICAL THERAPY	0.337441	164,927	55,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.198876	101,050	20,096	67.00
68.00	06800	SPEECH PATHOLOGY	0.269926	107,751	29,085	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061495	834,677	51,328	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.324656	20,876	6,778	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206253	1,637,832	337,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494326	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126697	7,184,957	910,312	73.00
74.00	07400	RENAL DIALYSIS	0.291751	201,780	58,870	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.169335	193	33	90.00
91.00	09100	EMERGENCY	0.154788	661,313	102,363	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.333686	118,650	39,592	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,811,664	3,389,952	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)		21,811,664		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A
Date/Time Prepared:
7/28/2022 12:38 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			10,360,760	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			3,697,212	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)			247,853	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			174,763	2.04
3.00	Managed Care Simulated Payments			7,943,621	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			206.02	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			1.56	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.11	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).			1.50	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			2.95	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			2.88	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			2.88	12.00
13.00	Total allowable FTE count for the prior year.			0.93	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.			1.27	14.00
15.00	Sum of lines 12 through 14 divided by 3.			1.69	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			1.69	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.008203	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.004503	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.004503	21.00
22.00	IME payment adjustment (see instructions)			34,554	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			19,525	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			-0.07	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)			34,554	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			19,525	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			9.17	30.00
31.00	Percentage of Medicaid patient days (see instructions)			24.95	31.00
32.00	Sum of lines 30 and 31			34.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)			17.36	33.00
34.00	Disproportionate share adjustment (see instructions)			610,116	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/28/2022 12:38 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,388,329	1,556,618		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,038,394	392,353		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,430,747			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		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 (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			45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	16,556,005			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)		16,575,530		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,193,588		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).		85,875		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		249,884		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		18,104,877		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,104,877		61.00
62.00	Deductibles billed to program beneficiaries		1,341,272		62.00
63.00	Coinsurance billed to program beneficiaries		80,450		63.00
64.00	Allowable bad debts (see instructions)		328,583		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		213,579		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		212,040		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		16,896,734		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		0		70.93
70.94	HRR adjustment amount (see instructions)		-66,079		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 7/28/2022 12:38 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,830,655	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		16,851,545	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)		-20,890	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		464,365	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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2022 12:38 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,360,760	0	10,360,760		10,360,760
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,697,212	0		3,697,212	3,697,212
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	247,853	0	247,853		247,853
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	174,763	0		174,763	174,763
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	7,943,621	0	5,894,713	2,048,908	7,943,621
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.004503	0.004503	0.004503	0.004503	
6.00	IME payment adjustment (see instructions)	22.00	34,554	0	25,466	9,088	34,554
6.01	IME payment adjustment for managed care (see instructions)	22.01	19,525	0	14,489	5,036	19,525
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	34,554	0	25,466	9,088	34,554
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	19,525	0	14,489	5,036	19,525
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1736	0.1736	0.1736	0.1736	
11.00	Disproportionate share adjustment (see instructions)	34.00	610,116	0	449,657	160,459	610,116
11.01	Uncompensated care payments	36.00	1,430,747	0	1,038,394	392,353	1,430,747
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	16,556,005	0	12,122,130	4,433,875	16,556,005
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	16,575,530	0	12,136,619	4,438,911	16,575,530
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,193,588	0	883,366	310,222	1,193,588

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/28/2022 12:38 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	249,884	0	151,370	98,513	249,883	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	13,171,355	4,847,646	18,019,001	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	1,071,677	0	792,829	278,848	1,071,677	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	37,677	0	28,221	9,456	37,677	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	0.0071	0.0071	0.0071	0.0071		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,609	0	5,629	1,980	7,609	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0715	0.0715	0.0715	0.0715		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	76,625	0	56,687	19,938	76,625	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,193,588	0	883,366	310,222	1,193,588	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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2022 12:38 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,360,760	10,360,760		10,360,760	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,697,212		3,697,212	3,697,212	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	247,853	247,853		247,853	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	174,763		174,763	174,763	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,943,621	5,894,713	2,048,908	7,943,621	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.004503	0.004503	0.004503		5.00
6.00	IME payment adjustment (see instructions)	22.00	34,554	25,466	9,088	34,554	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	19,525	14,489	5,036	19,525	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	34,554	25,466	9,088	34,554	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	19,525	14,489	5,036	19,525	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1736	0.1736	0.1736		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	610,116	449,657	160,459	610,116	11.00
11.01	Uncompensated care payments	36.00	1,430,747	1,038,394	392,353	1,430,747	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	16,556,005	12,122,130	4,433,875	16,556,005	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	16,575,530	12,136,619	4,438,911	16,575,530	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,193,588	883,366	310,222	1,193,588	16.00
17.00	Special add-on payments for new technologies	54.00	249,884	151,371	98,513	249,884	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			13,171,356	4,847,646	18,019,002	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2022 12:38 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,071,677	792,829	278,848	1,071,677	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	37,677	28,221	9,456	37,677	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	0.0071	0.0071	0.0071		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,609	5,629	1,980	7,609	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0715	0.0715	0.0715		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	76,625	56,687	19,938	76,625	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,193,588	883,366	310,222	1,193,588	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	0	0	0	0	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	-66,079	-45,203	-20,876	-66,079	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: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/28/2022 12:38 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,174	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,515,553	2.00
3.00	OPPS payments		3,183,772	3.00
4.00	Outlier payment (see instructions)		3,415	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,174	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		14,963	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		14,963	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		14,963	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,789	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,174	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)		3,187,187	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)		628,378	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,560,983	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		10,566	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,571,549	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,571,549	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)		194,805	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		126,623	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		94,112	36.00
37.00	Subtotal (see instructions)		2,698,172	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)		2,698,172	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		3,003,460	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)		-305,288	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/28/2022 12:38 am	
		Title XVIII	Hospital	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00	Part B Combined Billed Days				0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/28/2022 12:38 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		141	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)		141	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,114	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)		1,114	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)		1,114	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		973	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)		141	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)		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)		141	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)		141	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		141	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)		141	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)		141	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		145	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)		-4	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 7/28/2022 12:38 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
MEDICARE PART B ANCILLARY COSTS				
200.00	Part B Combined Billed Days			200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
7/28/2022 12:38 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		16,479,506		2,838,123	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	10/20/2021	372,039	10/20/2021	165,337	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)		372,039		165,337	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,851,545		3,003,460	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		20,890		305,288	6.02	
7.00	Total Medicare program liability (see instructions)		16,830,655		2,698,172	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: 14-0251
 Component CCN: 14-5548

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 7/28/2022 12:38 am

		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				
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		4,280,772		145
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		4,280,772		145
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		4
7.00	Total Medicare program liability (see instructions)		4,280,772		141
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 7/28/2022 12:38 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VI Date/Time Prepared: 7/28/2022 12:38 am
		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)			4,712,880 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			4,712,880 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			432,108 7.00
8.00	Allowable bad debts (see instructions)			0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0 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)			4,280,772 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
14.98	Recovery of accelerated depreciation.			0 14.98
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			4,280,772 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			4,280,772 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)			0 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: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet E-3
Part VII
Date/Time Prepared:
7/28/2022 12:38 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		6,350,054		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,413,555	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,413,555	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		8,601,693		8.00
9.00	Ancillary service charges		21,811,664	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)		30,413,357	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)		30,413,357	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		23,999,802	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,413,555	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,413,555	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,413,555	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,413,555	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-1,779,988	0	37.00
38.00	Subtotal (line 36 ± line 37)		4,633,567	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,633,567	0	40.00
41.00	Interim payments		4,633,567	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0251 Component CCN: 14-5548	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 7/28/2022 12:38 am
		Title XIX	Skilled Nursing Facility	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	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	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	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: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/28/2022 12:38 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			1.56	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.13	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))			1.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			2.68	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.88	6.00
7.00	Enter the lesser of line 5 or line 6			2.68	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.88	2.88	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.68	2.68	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.68		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.93		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.27		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.63		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	1.63		17.00
18.00	Per resident amount	109,620.72	106,489.91		18.00
19.00	Approved amount for resident costs	0	173,579	173,579	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)			0.20	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)			173,579	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	8,735	5,185		26.00
27.00	Total Inpatient Days (see instructions)	24,674	24,674		27.00
28.00	Ratio of inpatient days to total inpatient days	0.354016	0.210140		28.00
29.00	Program direct GME amount	61,450	36,476	97,926	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,485	1,485	30.00
31.00	Net Program direct GME amount			96,441	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 7/28/2022 12:38 am	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,750,811	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)			28,592,316	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)			28,592,316	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			3,517,868	42.00
43.00	Primary payer payments (see instructions)			0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			3,517,868	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			32,110,184	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.890444	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.109556	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			96,441	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			85,875	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			10,566	50.00

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

Provider CCN: 14-0251

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

Worksheet G

Date/Time Prepared:
7/28/2022 12:38 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,016,634	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	168,179,553	0	0	0	4.00
5.00	Other receivable	3,877,673	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-105,419,109	0	0	0	6.00
7.00	Inventory	11,929,187	0	0	0	7.00
8.00	Prepaid expenses	806,311	0	0	0	8.00
9.00	Other current assets	722,840	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	88,113,089	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	46,197,164	0	0	0	15.00
16.00	Accumulated depreciation	-7,733,764	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	38,463,400	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	126,576,489	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	36,346,205	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,849,134	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	37,834	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	30,628,499	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	73,861,672	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	41,025,607	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,025,607	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	114,887,279	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,689,210				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,689,210	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	126,576,489	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0251

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

Worksheet G-1

Date/Time Prepared:
7/28/2022 12:38 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,480,538		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-791,328				2.00
3.00	Total (sum of line 1 and line 2)		11,689,210		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,689,210		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,689,210		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0251

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2022 12:38 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	55,638,565		55,638,565	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	12,120,026		12,120,026	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)	67,758,591		67,758,591	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	18,280,780		18,280,780	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	18,280,780		18,280,780	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	86,039,371		86,039,371	17.00
18.00	Ancillary services	216,358,985		216,358,985	18.00
19.00	Outpatient services	0	140,297,013	140,297,013	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	PHYSICIANS REV	0	17,888,514	17,888,514	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	302,398,356	158,185,527	460,583,883	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		104,883,063		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		104,883,063		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0251

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

Worksheet G-3

Date/Time Prepared:
7/28/2022 12:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	460,583,883	1.00
2.00	Less contractual allowances and discounts on patients' accounts	378,042,052	2.00
3.00	Net patient revenues (line 1 minus line 2)	82,541,831	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	104,883,063	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-22,341,232	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	192,006	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	2,976	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GAIN UPON DEBT EXTINGUISHMENT FINAN	10,000,000	24.00
24.01	OTHER MISCELLANEOUS REVENUE - POB	320,811	24.01
24.02	OTHER MISC REV	56,334	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.50	COVID-19 PHE Funding	10,977,777	24.50
25.00	Total other income (sum of lines 6-24)	21,549,904	25.00
26.00	Total (line 5 plus line 25)	-791,328	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-791,328	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0251	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 7/28/2022 12:38 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,071,677	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		37,677	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)		67.60	3.00
4.00	Number of interns & residents (see instructions)		1.69	4.00
5.00	Indirect medical education percentage (see instructions)		0.71	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)		7,609	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		9.17	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.95	8.00
9.00	Sum of lines 7 and 8		34.12	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.15	10.00
11.00	Disproportionate share adjustment (see instructions)		76,625	11.00
12.00	Total prospective capital payments (see instructions)		1,193,588	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