

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: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/23/2021 9:22 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/23/2021	Time: 9:22 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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - SILVIS (14-0275) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JOSEPH MALAS
Officer or Administrator of Provider(s)

VICE PRESIDENT, FINANCE
Title

11/23/2021 09:22:12 AM
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	259,199	-18,034	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	259,199	-18,034	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: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:22 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 801 ILLINI DR			PO Box:				1.00			
2.00	City: SILVIS			State: IL		Zip Code: 61282-		County: ROCK ISLAND			
		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		GENESIS MEDICAL CENTER - SILVIS		140275	19340	1	07/01/1966	N	P	N
4.00	Subprovider - IPF										3.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF										6.00
8.00	Swing Beds - NF										7.00
9.00	Hospital-Based SNF										8.00
10.00	Hospital-Based NF										9.00
11.00	Hospital-Based OLTC										10.00
12.00	Hospital-Based HHA										11.00
13.00	Separately Certified ASC										12.00
14.00	Hospital-Based Hospice										13.00
15.00	Hospital-Based Health Clinic - RHC										14.00
16.00	Hospital-Based Health Clinic - FQHC										15.00
17.00	Hospital-Based (CMHC) I										16.00
18.00	Renal Dialysis										17.00
19.00	Other										18.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)						2			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	

Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 9:22 am

3 | Page

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:22 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/23/2021 9:22 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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:22 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:22 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	235,544118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/23/2021 9:22 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: GENESIS HEALTH SYSTEM	Contractor's Name: WPS		Contractor's Number: 05001				141.00	
142.00	Street: 1227 E. RUSHOLME STREET	PO Box:						142.00	
143.00	City: DAVENPORT	State: IA		Zip Code: 52803				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.							N	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.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 9:22 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	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/19/2021	Y	10/19/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/23/2021 9:22 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRENT	DAILY	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-1985	DAILYBR@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/23/2021 9:22 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, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 9:22 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	138	50,370	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)		138	50,370	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		145	52,925	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		145			0	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)		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: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 9:22 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)	2,472	668	7,823			1.00
2.00	HMO and other (see instructions)	2,523	1,858				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,472	668	7,823			7.00
8.00	INTENSIVE CARE UNIT	579	0	1,474			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	888			13.00
14.00	Total (see instructions)	3,051	668	10,185	0.00	414.68	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	414.68	27.00
28.00	Observation Bed Days		0	2,054			28.00
29.00	Ambulance Trips	2,541					29.00
30.00	Employee discount days (see instruction)			75			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	94	160			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: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/23/2021 9:22 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	817	217	3,248	1.00
2.00 HMO and other (see instructions)			562	0		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	817	217	3,248	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 9:22 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	24,925,285	0	24,925,285	787,348.00	31.66
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,761,380	1,249	2,762,629	131,931.67	20.94
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		947,434	0	947,434	11,552.00	82.01
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		27,298	0	27,298	268.00	101.86
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		6,334,082	0	6,334,082	161,494.00	39.22
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,886,789	0	3,886,789		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		484,351	0	484,351		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		961,306	0	961,306		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/23/2021 9:22 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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,295,927	0	2,295,927	35,821.00	64.09	27.00
28.00	Administrative & General under contract (see inst.)		113,384	0	113,384	1,190.00	95.28	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	566,969	0	566,969	26,653.00	21.27	30.00
31.00	Laundry & Linen Service	8.00	39,975	-1,249	38,726	3,492.00	11.09	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		602,736	0	602,736	52,100.00	11.57	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		279,237	0	279,237	24,347.00	11.47	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	820,694	0	820,694	22,483.00	36.50	38.00
39.00	Central Services and Supply	14.00	104,544	0	104,544	6,198.00	16.87	39.00
40.00	Pharmacy	15.00	1,830,583	0	1,830,583	40,980.00	44.67	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/23/2021 9:22 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)	25,920,642	0	25,920,642	864,985.00	29.97	1.00
2.00	Excluded area salaries (see instructions)	2,761,380	1,249	2,762,629	131,931.67	20.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,159,262	-1,249	23,158,013	733,053.33	31.59	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,308,814	0	7,308,814	173,314.00	42.17	4.00
5.00	Subtotal wage-related costs (see inst.)	4,848,095	0	4,848,095	0.00	20.93	5.00
6.00	Total (sum of lines 3 thru 5)	35,316,171	-1,249	35,314,922	906,367.33	38.96	6.00
7.00	Total overhead cost (see instructions)	6,654,049	-1,249	6,652,800	213,264.00	31.20	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2021 9:22 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		223,905	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)		21,147	8.02
8.03	Health Insurance (Purchased)		1,198,838	8.03
9.00	Prescription Drug Plan		32,742	9.00
10.00	Dental, Hearing and Vision Plan		488,324	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		96,694	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		3,175	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)		95,693	14.00
15.00	'Workers' Compensation Insurance		322,221	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,781,629	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		89,643	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		100	22.00
23.00	Tuition Reimbursement		17,029	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		4,371,140	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: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/23/2021 9:22 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	947,434	4,371,140	1.00
2.00	Hospital	947,434	4,371,140	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/23/2021 9:22 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)			0.264851 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	14,676,537		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	56,881,418		6.00
7.00	Medicaid cost (line 1 times line 6)	15,065,100		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)	388,563		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)	388,563		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)	1,271,516	1,426,755	2,698,271 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	336,762	1,426,755	1,763,517 21.00
22.00	Payments received from patients for amounts previously written off as charity care	9,743	48,085	57,828 22.00
23.00	Cost of charity care (line 21 minus line 22)	327,019	1,378,670	1,705,689 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,457,569		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	295,290		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	454,293		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,003,276		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	954,424		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,660,113		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,048,676		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0275

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

Worksheet A

Date/Time Prepared:
11/23/2021 9:22 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	NEW CAP REL COSTS-BLDG & FIXT		2,124,006	2,124,006	40,660	2,164,666	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,901,473	1,901,473	68,501	1,969,974	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,493,160	2,493,160	0	2,493,160	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,295,927	27,692,735	29,988,662	-152,036	29,836,626	5.00
7.00	00700	OPERATION OF PLANT	566,969	1,735,297	2,302,266	0	2,302,266	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,975	47,089	87,064	-2,720	84,344	8.00
9.00	00900	HOUSEKEEPING	0	811,796	811,796	-50,748	761,048	9.00
10.00	01000	DIETARY	0	1,107,608	1,107,608	-496,418	611,190	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	820,694	100,595	921,289	0	921,289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,544	138,539	243,083	0	243,083	14.00
15.00	01500	PHARMACY	1,830,583	482,612	2,313,195	0	2,313,195	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,976,352	1,361,583	5,337,935	-359,709	4,978,226	30.00
31.00	03100	INTENSIVE CARE UNIT	678,426	281,698	960,124	0	960,124	31.00
43.00	04300	NURSERY	0	0	0	359,709	359,709	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,680,582	1,318,601	2,999,183	0	2,999,183	50.00
53.00	05300	ANESTHESIOLOGY	0	33,050	33,050	0	33,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,020,138	1,233,454	2,253,592	0	2,253,592	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,016,061	10,218,656	11,234,717	0	11,234,717	55.00
57.00	05700	CT SCAN	252,038	225,351	477,389	0	477,389	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	122,786	84,506	207,292	0	207,292	58.00
59.00	05900	CARDIAC CATHETERIZATION	451,734	671,252	1,122,986	0	1,122,986	59.00
60.00	06000	LABORATORY	2,263,550	5,108,702	7,372,252	0	7,372,252	60.00
65.00	06500	RESPIRATORY THERAPY	1,126,391	431,619	1,558,010	0	1,558,010	65.00
66.00	06600	PHYSICAL THERAPY	1,399,229	579,340	1,978,569	0	1,978,569	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,721,743	3,721,743	-2,521,464	1,200,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,521,464	2,521,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,595,923	2,595,923	0	2,595,923	73.00
76.97	07697	CARDIAC REHABILITATION	264,783	100,002	364,785	0	364,785	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	238,551	197,544	436,095	0	436,095	90.01
91.00	09100	EMERGENCY	2,014,592	4,483,117	6,497,709	0	6,497,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,737,048	1,297,144	4,034,192	38,255	4,072,447	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,900,953	72,578,195	97,479,148	-554,506	96,924,642	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,785	8,785	8,593	17,378	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,332	654,983	679,315	3,900	683,215	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	42,875	42,875	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	1,056	1,056	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	283,872	283,872	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	212,546	212,546	194.03
194.04	07951	OUTREACH	0	1,822	1,822	1,664	3,486	194.04
194.05	07956	RETAIL PHARMACY	0	791,441	791,441	0	791,441	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	24,925,285	74,035,226	98,960,511	0	98,960,511	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0275

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

Worksheet A

Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-36,928	2,127,738	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	1,969,974	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-659,767	1,833,393	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,764,185	19,072,441	5.00
7.00	00700	OPERATION OF PLANT	-58,619	2,243,647	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-768	83,576	8.00
9.00	00900	HOUSEKEEPING	0	761,048	9.00
10.00	01000	DIETARY	0	611,190	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	921,289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	326,263	569,346	14.00
15.00	01500	PHARMACY	-13,480	2,299,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,156,670	1,156,670	16.00
17.00	01700	SOCIAL SERVICE	64,572	64,572	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-12,178	4,966,048	30.00
31.00	03100	INTENSIVE CARE UNIT	-11,538	948,586	31.00
43.00	04300	NURSERY	0	359,709	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,999,183	50.00
53.00	05300	ANESTHESIOLOGY	0	33,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-201,306	2,052,286	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,234,717	55.00
57.00	05700	CT SCAN	0	477,389	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	207,292	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,122,986	59.00
60.00	06000	LABORATORY	-493,263	6,878,989	60.00
65.00	06500	RESPIRATORY THERAPY	-35,658	1,522,352	65.00
66.00	06600	PHYSICAL THERAPY	-107,684	1,870,885	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,200,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,521,464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,595,923	73.00
76.97	07697	CARDIAC REHABILITATION	0	364,785	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CENTER	-63,779	372,316	90.01
91.00	09100	EMERGENCY	-3,964,924	2,532,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,420,572	2,651,875	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,297,144	80,627,498	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,378	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	683,215	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	42,875	192.01
194.00	07950	CROSSTOWN SQUARE	0	1,056	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	283,872	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	212,546	194.03
194.04	07951	OUTREACH	0	3,486	194.04
194.05	07956	RETAIL PHARMACY	0	791,441	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,297,144	82,663,367	200.00

RECLASSIFICATIONS

Provider CCN: 14-0275

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 9:22 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - POB DEPRECIATION					
1.00 PHYSICIAN OFFICE BUILDING	192.01	0	42,875		1.00
0		0	42,875		
B - PROPERTY INSURANCE					
1.00 OTHER CAPITAL RELATED COSTS	3.00	0	152,036		1.00
TOTALS		0	152,036		
C - NURSERY COSTS					
1.00 NURSERY	43.00	295,996	63,713		1.00
0		295,996	63,713		
D - CHARGEABLE IMPLANTS/SUPPLIES					
1.00 IMPL. DEV. CHARGED TO	72.00	0	2,521,464		1.00
PATIENT					
0		0	2,521,464		
E - DIETARY COST AND EMPLOYEE MEALS					
1.00 NONALLOW PHYSICIAN MEALS	194.02	0	283,872		1.00
2.00 NONALLOWABLE GUEST MEALS	194.03	0	212,546		2.00
0		0	496,418		
F - HOUSEKEEPING COST					
1.00 AMBULANCE SERVICES	95.00	0	38,255		1.00
2.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	8,593		2.00
3.00 PHYSICIANS' PRIVATE OFFICES	192.00	0	3,900		3.00
0		0	50,748		
G - LAUNDRY COST					
1.00 CROSSTOWN SQUARE	194.00	485	571		1.00
2.00 OUTREACH	194.04	764	900		2.00
0		1,249	1,471		
500.00 Grand Total: Increases		297,245	3,328,725		500.00

RECLASSIFICATIONS

Provider CCN: 14-0275

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

Worksheet A-6

Date/Time Prepared:
11/23/2021 9:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - POB DEPRECIATION						
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	42,875	9		1.00
	0		0	42,875			
1.00	B - PROPERTY INSURANCE						
	ADMINISTRATIVE & GENERAL	5.00	0	152,036	0		1.00
	TOTALS		0	152,036			
1.00	C - NURSERY COSTS						
	ADULTS & PEDIATRICS	30.00	295,996	63,713	0		1.00
	0		295,996	63,713			
1.00	D - CHARGEABLE IMPLANTS/SUPPLIES						
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,521,464	0		1.00
	0		0	2,521,464			
1.00	E - DIETARY COST AND EMPLOYEE MEALS						
	DIETARY	10.00	0	283,872	0		1.00
2.00	DIETARY	10.00	0	212,546	0		2.00
	0		0	496,418			
1.00	F - HOUSEKEEPING COST						
	HOUSEKEEPING	9.00	0	50,748	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	50,748			
1.00	G - LAUNDRY COST						
	LAUNDRY & LINEN SERVICE	8.00	1,249	1,471	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,249	1,471			
500.00	Grand Total: Decreases		297,245	3,328,725			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/23/2021 9:22 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	2,295,238	9,161	0	9,161	0	1.00	
2.00	Land Improvements	5,049,135	121,391	0	121,391	0	2.00	
3.00	Buildings and Fixtures	52,042,260	4,143,501	0	4,143,501	0	3.00	
4.00	Building Improvements	2,115,300	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	52,322,283	1,615,221	0	1,615,221	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	113,824,216	5,889,274	0	5,889,274	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	113,824,216	5,889,274	0	5,889,274	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,304,399	0				1.00	
2.00	Land Improvements	5,170,526	0				2.00	
3.00	Buildings and Fixtures	56,185,761	0				3.00	
4.00	Building Improvements	2,115,300	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	53,937,504	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	119,713,490	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	119,713,490	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/23/2021 9:22 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	NEW CAP REL COSTS-BLDG & FIXT	2,087,078	0	36,928	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,901,473	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,988,551	0	36,928	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,124,006				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,901,473				2.00
3.00	Total (sum of lines 1-2)	0	4,025,479				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/23/2021 9:22 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	NEW CAP REL COSTS-BLDG & FIXT	65,775,986	0	65,775,986	0.549445	83,535	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	53,937,504	0	53,937,504	0.450555	68,501	2.00
3.00	Total (sum of lines 1-2)	119,713,490	0	119,713,490	1.000000	152,036	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	83,535	2,044,203	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	68,501	1,901,473	0	2.00
3.00	Total (sum of lines 1-2)	0	0	152,036	3,945,676	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	83,535	0	0	2,127,738	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	68,501	0	0	1,969,974	2.00
3.00	Total (sum of lines 1-2)	0	152,036	0	0	4,097,712	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
11/23/2021 9:22 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				3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,229,611			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	-645,227			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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 - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:

11/23/2021 9:22 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADMINISTRATION - RENTAL INCOME - 3RD	B	-43,400	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADMINISTRATION - DISCOUNTS	B	-1,026	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ADMINISTRATION - INV INC - WELLSPIRE	B	121,911	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADMINISTRATION - INV INC - GENRAD IM	B	-122,304	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	INFORMATION TECHNOLOGY - MISC INCOME	B	-2,852	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MEDICAL STAFF - ILLINI - MISC INCOME	B	-42,120	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	SWITCHBOARD - MISC INCOME	B	-320	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	GROUPS - MISC INCOME	B	-45,449	OPERATION OF PLANT	7.00	0	33.07
33.08	BIRTH ASSOCIATES - MISC INCOME	B	-640	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	GIC-MLI-GENRAD IL - OUTREACH REVENUE	B	-200,459	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	LABORATORY - MISC INCOME	B	-493,263	LABORATORY	60.00	0	33.10
33.11	PHYSICAL THERAPY - MISC INCOME	B	-22,203	PHYSICAL THERAPY	66.00	0	33.11
33.12	PHYSICAL THERAPY - MOLINE MISC INCOM	B	-482	PHYSICAL THERAPY	66.00	0	33.12
33.13	TRAUMA - MISC INCOME	B	-32,003	EMERGENCY	91.00	0	33.13
33.14	AMBULANCE - CPE REVENUE	B	-18,600	AMBULANCE SERVICES	95.00	0	33.14
33.15	AMBULANCE - MISC INCOME	B	-724,923	AMBULANCE SERVICES	95.00	0	33.15
33.16	AMBULANCE - OUTREACH - MISC	B	-677,029	AMBULANCE SERVICES	95.00	0	33.16
33.17	MAMMOGRAPHY - MISC INCOME	B	-600	RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.18	PT - INTERCOMPANY REV	B	-8,398	PHYSICAL THERAPY	66.00	0	33.18
33.19	PT - MOLINE HEALTHPLEX - INTERCOMPAN	B	-56,050	PHYSICAL THERAPY	66.00	0	33.19
33.20	PT - MOLINE 7TH ST - INTERCOMPANY	B	-20,053	PHYSICAL THERAPY	66.00	0	33.20
33.21	PHARMACY - INTERCOMPANY	B	-13,480	PHARMACY	15.00	0	33.21
33.22	GROUPS - INTERCOMPANY	B	-4,962	OPERATION OF PLANT	7.00	0	33.22
33.23	LAUNDRY - INTERCOMPANY	B	-768	LAUNDRY & LINEN SERVICE	8.00	0	33.23
33.24	SECURITY - INTERCOMPANY	B	-8,208	OPERATION OF PLANT	7.00	0	33.24
34.00	ADMINISTRATION - PHYSICIAN PRACTICE	A	-5,123,630	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN SUPPORT SERVICES	A	-226,086	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	DONATIONS	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	ADVERTISING & PROMOTIONS	A	-10,062	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	ADVERTISING & PROMOTIONS	A	-247	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
40.00	ADVERTISING & PROMOTIONS	A	-498	PHYSICAL THERAPY	66.00	0	40.00
41.00	ADMINISTRATION - PROVIDER TAXES	A	-2,923,438	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	SELF INSURANCE	A	-659,767	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00	LOBBYING PORTION OF DUES	A	-18,969	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	INTEREST EXPENSE - 2010 B	A	-60,093	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.00
45.00	INTEREST EXPENSE - CAP INT OFFSET	A	23,165	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,297,144				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0275

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

Worksheet A-8-1

Date/Time Prepared:

11/23/2021 9:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	11,241,109	13,433,841	1.00
2.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	326,263	0	2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	1,156,670	0	3.00
4.00	17.00	SOCIAL SERVICE	GHS HOME OFFICE COSTS	64,572	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	VARIOUS SERVICES - RELATED	340,458	340,458	4.01
4.02	7.00	OPERATION OF PLANT	VARIOUS SERVICES - RELATED	450	450	4.02
4.03	13.00	NURSING ADMINISTRATION	VARIOUS SERVICES - RELATED	80	80	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	VARIOUS SERVICES - RELATED	1,479	1,479	4.04
4.05	15.00	PHARMACY	VARIOUS SERVICES - RELATED	77,578	77,578	4.05
4.06	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	49,474	49,474	4.06
4.07	31.00	INTENSIVE CARE UNIT	VARIOUS SERVICES - RELATED	10,141	10,141	4.07
4.08	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	48,915	48,915	4.08
4.09	53.00	ANESTHESIOLOGY	VARIOUS SERVICES - RELATED	486	486	4.09
4.10	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	15,737	15,737	4.10
4.11	55.00	RADIOLOGY-THERAPEUTIC	VARIOUS SERVICES - RELATED	13,321	13,321	4.11
4.12	57.00	CT SCAN	VARIOUS SERVICES - RELATED	8,345	8,345	4.12
4.13	58.00	MAGNETIC RESONANCE IMAGING (	VARIOUS SERVICES - RELATED	1,887	1,887	4.13
4.14	59.00	CARDIAC CATHETERIZATION	VARIOUS SERVICES - RELATED	3,143	3,143	4.14
4.15	60.00	LABORATORY	VARIOUS SERVICES - RELATED	534,520	534,520	4.15
4.16	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	41,315	41,315	4.16
4.17	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	172,958	172,958	4.17
4.18	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	89,457	89,457	4.18
4.19	76.97	CARDIAC REHABILITATION	VARIOUS SERVICES - RELATED	67,150	67,150	4.19
4.20	90.01	WOUND CENTER	VARIOUS SERVICES - RELATED	25,702	25,702	4.20
4.21	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	118,512	118,512	4.21
4.22	95.00	AMBULANCE SERVICES	VARIOUS SERVICES - RELATED	5,118	5,118	4.22
4.23	190.00	GIFT, FLOWER, COFFEE SHOP &	VARIOUS SERVICES - RELATED	2,260	2,260	4.23
4.24	194.05	RETAIL PHARMACY	VARIOUS SERVICES - RELATED	2,146	2,146	4.24
5.00	0		0	14,419,246	15,064,473	5.00

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

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

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

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

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

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

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

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

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

Provider CCN: 14-0275

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

Worksheet A-8-1

Date/Time Prepared:
11/23/2021 9:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-2,192,732	0		1.00
2.00	326,263	0		2.00
3.00	1,156,670	0		3.00
4.00	64,572	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
5.00	-645,227			5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0275

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

Worksheet A-8-2

Date/Time Prepared:
11/23/2021 9:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	181,377	174,127	7,250	211,500	71	1.00
2.00	30.00	ADULTS & PEDIATRICS	11,538	11,538	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	35,658	35,658	0	0	0	4.00
5.00	90.01	WOUND CENTER	63,779	63,779	0	0	0	5.00
6.00	91.00	EMERGENCY	3,942,171	3,932,921	9,250	211,500	91	6.00
7.00	95.00	AMBULANCE SERVICES	10,798	0	10,798	211,500	106	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			4,256,859	4,229,561	27,298		268	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	7,220	361	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.01	WOUND CENTER	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	9,253	463	0	0	0	6.00
7.00	95.00	AMBULANCE SERVICES	10,778	539	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			27,251	1,363	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	7,220	30	174,157		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	11,538		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	35,658		4.00
5.00	90.01	WOUND CENTER	0	0	0	63,779		5.00
6.00	91.00	EMERGENCY	0	9,253	0	3,932,921		6.00
7.00	95.00	AMBULANCE SERVICES	0	10,778	20	20		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	27,251	50	4,229,611		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,127,738	2,127,738			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,969,974		1,969,974		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,833,393	5,176	0	1,838,569	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,072,441	496,789	128,341	169,354	5.00
7.00	00700	OPERATION OF PLANT	2,243,647	200,831	53,559	41,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,576	22,127	0	2,857	8.00
9.00	00900	HOUSEKEEPING	761,048	10,093	19,897	0	9.00
10.00	01000	DIETARY	611,190	48,810	9,972	0	10.00
11.00	01100	CAFETERIA	0	27,099	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	921,289	7,209	51,310	60,537	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	569,346	61,814	20,271	7,711	14.00
15.00	01500	PHARMACY	2,299,715	42,885	72,306	135,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,156,670	25,436	0	0	16.00
17.00	01700	SOCIAL SERVICE	64,572	10,204	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,966,048	397,559	127,076	271,481	30.00
31.00	03100	INTENSIVE CARE UNIT	948,586	34,567	23,214	50,043	31.00
43.00	04300	NURSERY	359,709	20,047	20,687	21,834	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,999,183	148,870	482,867	123,965	50.00
53.00	05300	ANESTHESIOLOGY	33,050	0	2,334	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,052,286	81,871	229,658	75,248	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,234,717	0	18,902	74,948	55.00
57.00	05700	CT SCAN	477,389	0	9,364	18,591	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,292	1,682	254,161	9,057	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,122,986	22,256	34,947	33,321	59.00
60.00	06000	LABORATORY	6,878,989	138,490	38,492	166,966	60.00
65.00	06500	RESPIRATORY THERAPY	1,522,352	25,990	106,638	83,086	65.00
66.00	06600	PHYSICAL THERAPY	1,870,885	31,295	24,436	103,211	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,200,279	0	75,406	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,521,464	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,595,923	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	364,785	80,410	651	19,531	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	372,316	17,496	9,671	17,596	90.01
91.00	09100	EMERGENCY	2,532,785	81,667	31,325	148,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,651,875	65,631	116,811	201,893	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,627,498	2,106,304	1,962,296	1,836,682	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,378	14,742	94	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	683,215	6,692	7,584	1,795	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	42,875	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	1,056	0	0	36	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	283,872	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	212,546	0	0	0	194.03
194.04	07951	OUTREACH	3,486	0	0	56	194.04
194.05	07956	RETAIL PHARMACY	791,441	0	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	82,663,367	2,127,738	1,969,974	1,838,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,866,925				5.00
7.00	00700	OPERATION OF PLANT	803,535	3,343,393			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,345	51,917	194,822		8.00
9.00	00900	HOUSEKEEPING	250,261	23,681	0	1,064,980	9.00
10.00	01000	DIETARY	211,959	114,524	0	39,813	10.00
11.00	01100	CAFETERIA	8,573	63,584	0	22,104	11.00
13.00	01300	NURSING ADMINISTRATION	329,134	16,915	0	5,880	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	208,533	145,037	1,715	50,420	14.00
15.00	01500	PHARMACY	806,723	100,624	0	34,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	373,983	59,680	0	20,747	16.00
17.00	01700	SOCIAL SERVICE	23,657	23,941	0	8,323	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,822,976	932,808	49,752	324,275	30.00
31.00	03100	INTENSIVE CARE UNIT	334,216	81,106	10,997	28,195	31.00
43.00	04300	NURSERY	133,596	47,037	5,004	16,352	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,187,933	349,298	48,032	121,428	50.00
53.00	05300	ANESTHESIOLOGY	11,194	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	771,646	192,096	17,975	66,779	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,584,034	0	0	0	55.00
57.00	05700	CT SCAN	159,876	0	9,543	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,387	3,947	2,177	1,372	58.00
59.00	05900	CARDIAC CATHETERIZATION	383,918	52,220	3,557	18,153	59.00
60.00	06000	LABORATORY	2,285,121	324,945	36	112,962	60.00
65.00	06500	RESPIRATORY THERAPY	549,872	60,981	1,462	21,199	65.00
66.00	06600	PHYSICAL THERAPY	642,176	73,429	3,030	25,526	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	403,588	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	797,716	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	821,272	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	147,231	188,669	95	65,588	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	131,951	41,052	523	14,271	90.01
91.00	09100	EMERGENCY	884,058	191,619	40,924	66,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	960,566	153,993	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,213,030	3,293,103	194,822	1,064,980	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,192	34,589	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	221,233	15,701	0	0	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	13,564	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	345	0	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	89,809	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	67,243	0	0	0	194.03
194.04	07951	OUTREACH	1,121	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	250,388	0	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,866,925	3,343,393	194,822	1,064,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	741,773					11.00
13.00	01300	NURSING ADMINISTRATION	22,732	1,415,006				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,266	0	1,071,113			14.00
15.00	01500	PHARMACY	41,426	0	22,350	3,556,038		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,636,516	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	105,078	604,240	62,580	0	111,709	30.00
31.00	03100	INTENSIVE CARE UNIT	18,820	95,631	19,022	0	26,400	31.00
43.00	04300	NURSERY	24,288	43,787	5,109	0	3,940	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	53,622	202,589	133,882	0	117,883	50.00
53.00	05300	ANESTHESIOLOGY	0	0	5,710	0	15,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,159	3,001	6,272	0	69,336	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	36,232	108,464	35,965	2,755,588	313,471	55.00
57.00	05700	CT SCAN	8,117	55	18,495	0	164,999	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,533	22	865	0	33,833	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,528	19,974	14,465	0	52,242	59.00
60.00	06000	LABORATORY	94,627	11,759	5,383	0	286,037	60.00
65.00	06500	RESPIRATORY THERAPY	38,019	323	20,935	0	78,110	65.00
66.00	06600	PHYSICAL THERAPY	41,846	0	1,783	0	39,131	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	208,577	0	24,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	442,136	0	50,323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	800,450	106,417	73.00
76.97	07697	CARDIAC REHABILITATION	8,306	13,615	792	0	4,898	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	5,657	29,225	6,411	0	17,209	90.01
91.00	09100	EMERGENCY	57,092	267,851	48,799	0	120,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	132,121	14,470	11,582	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	740,469	1,415,006	1,071,113	3,556,038	1,636,516	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,199	0	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	42	0	0	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	63	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	741,773	1,415,006	1,071,113	3,556,038	1,636,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	130,697				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,313	10,240,573	0	10,240,573	30.00
31.00	03100	INTENSIVE CARE UNIT	18,337	1,741,311	0	1,741,311	31.00
43.00	04300	NURSERY	11,047	712,437	0	712,437	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,969,552	0	5,969,552	50.00
53.00	05300	ANESTHESIOLOGY	0	67,795	0	67,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,601,327	0	3,601,327	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,162,321	0	18,162,321	55.00
57.00	05700	CT SCAN	0	866,429	0	866,429	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	667,328	0	667,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,765,567	0	1,765,567	59.00
60.00	06000	LABORATORY	0	10,343,807	0	10,343,807	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,508,967	0	2,508,967	65.00
66.00	06600	PHYSICAL THERAPY	0	2,856,748	0	2,856,748	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,912,410	0	1,912,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,811,639	0	3,811,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,324,062	0	4,324,062	73.00
76.97	07697	CARDIAC REHABILITATION	0	894,571	0	894,571	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	663,378	0	663,378	90.01
91.00	09100	EMERGENCY	0	4,471,846	0	4,471,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,308,942	0	4,308,942	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,697	79,891,010	0	79,891,010	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,995	0	76,995	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	937,419	0	937,419	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	56,439	0	56,439	192.01
194.00	07950	CROSSTOWN SQUARE	0	1,479	0	1,479	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	373,681	0	373,681	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	279,789	0	279,789	194.03
194.04	07951	OUTREACH	0	4,726	0	4,726	194.04
194.05	07956	RETAIL PHARMACY	0	1,041,829	0	1,041,829	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,697	82,663,367	0	82,663,367	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,176	0	5,176	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,197,797	496,789	128,341	2,822,927	5.00
7.00	00700	OPERATION OF PLANT	169,254	200,831	53,559	423,644	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,127	0	22,127	8.00
9.00	00900	HOUSEKEEPING	0	10,093	19,897	29,990	9.00
10.00	01000	DIETARY	8,986	48,810	9,972	67,768	10.00
11.00	01100	CAFETERIA	0	27,099	0	27,099	11.00
13.00	01300	NURSING ADMINISTRATION	5,035	7,209	51,310	63,554	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,664	61,814	20,271	96,749	14.00
15.00	01500	PHARMACY	89,736	42,885	72,306	204,927	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,436	0	25,436	16.00
17.00	01700	SOCIAL SERVICE	0	10,204	0	10,204	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	102,997	397,559	127,076	627,632	30.00
31.00	03100	INTENSIVE CARE UNIT	6,365	34,567	23,214	64,146	31.00
43.00	04300	NURSERY	0	20,047	20,687	40,734	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	198,816	148,870	482,867	830,553	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,334	2,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,656	81,871	229,658	321,185	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	22,047	0	18,902	40,949	55.00
57.00	05700	CT SCAN	12,220	0	9,364	21,584	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,045	1,682	254,161	260,888	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,297	22,256	34,947	59,500	59.00
60.00	06000	LABORATORY	219,299	138,490	38,492	396,281	60.00
65.00	06500	RESPIRATORY THERAPY	107,056	25,990	106,638	239,684	65.00
66.00	06600	PHYSICAL THERAPY	384,478	31,295	24,436	440,209	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	75,406	75,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	70,573	80,410	651	151,634	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	51,872	17,496	9,671	79,039	90.01
91.00	09100	EMERGENCY	33,653	81,667	31,325	146,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	237,236	65,631	116,811	419,678	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,949,082	2,106,304	1,962,296	8,017,682	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,742	94	14,836	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	384,051	6,692	7,584	398,327	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,333,133	2,127,738	1,969,974	8,430,845	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,823,405					5.00
7.00	00700	OPERATION OF PLANT	114,195	537,957				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,881	8,353	35,369			8.00
9.00	00900	HOUSEKEEPING	35,566	3,810	0	69,366		9.00
10.00	01000	DIETARY	30,123	18,427	0	2,593	118,911	10.00
11.00	01100	CAFETERIA	1,218	10,231	0	1,440	71,192	11.00
13.00	01300	NURSING ADMINISTRATION	46,775	2,722	0	383	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,636	23,337	311	3,284	0	14.00
15.00	01500	PHARMACY	114,648	16,190	0	2,278	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,149	9,603	0	1,351	0	16.00
17.00	01700	SOCIAL SERVICE	3,362	3,852	0	542	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	259,073	150,092	9,033	21,121	41,732	30.00
31.00	03100	INTENSIVE CARE UNIT	47,497	13,050	1,996	1,836	5,987	31.00
43.00	04300	NURSERY	18,986	7,568	909	1,065	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	168,823	56,203	8,720	7,909	0	50.00
53.00	05300	ANESTHESIOLOGY	1,591	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,663	30,908	3,263	4,350	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	509,357	0	0	0	0	55.00
57.00	05700	CT SCAN	22,721	0	1,732	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,230	635	395	89	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,561	8,402	646	1,182	0	59.00
60.00	06000	LABORATORY	324,750	52,284	7	7,358	0	60.00
65.00	06500	RESPIRATORY THERAPY	78,145	9,812	265	1,381	0	65.00
66.00	06600	PHYSICAL THERAPY	91,263	11,815	550	1,663	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,356	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	113,368	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,715	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	20,924	30,357	17	4,272	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	18,752	6,605	95	930	0	90.01
91.00	09100	EMERGENCY	125,638	30,832	7,430	4,339	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	136,511	24,778	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,730,477	529,866	35,369	69,366	118,911	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,448	5,565	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,441	2,526	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	1,928	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	49	0	0	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	12,763	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	9,556	0	0	0	0	194.03
194.04	07951	OUTREACH	159	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	35,584	0	0	0	0	194.05
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)	2,823,405	537,957	35,369	69,366	118,911	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	111,180					11.00
13.00	01300	NURSING ADMINISTRATION	3,407	117,012				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	939	0	154,278			14.00
15.00	01500	PHARMACY	6,209	0	3,219	347,852		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	89,539	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,750	49,965	9,014	0	6,110	30.00
31.00	03100	INTENSIVE CARE UNIT	2,821	7,908	2,740	0	1,444	31.00
43.00	04300	NURSERY	3,640	3,621	736	0	215	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,037	16,753	19,283	0	6,448	50.00
53.00	05300	ANESTHESIOLOGY	0	0	822	0	848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,270	248	903	0	3,792	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,431	8,969	5,180	269,551	17,173	55.00
57.00	05700	CT SCAN	1,217	5	2,664	0	9,025	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	530	2	125	0	1,851	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,128	1,652	2,083	0	2,858	59.00
60.00	06000	LABORATORY	14,183	972	775	0	15,645	60.00
65.00	06500	RESPIRATORY THERAPY	5,698	27	3,015	0	4,272	65.00
66.00	06600	PHYSICAL THERAPY	6,272	0	257	0	2,140	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	30,042	0	1,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	63,686	0	2,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	78,301	5,821	73.00
76.97	07697	CARDIAC REHABILITATION	1,245	1,126	114	0	268	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	848	2,417	923	0	941	90.01
91.00	09100	EMERGENCY	8,557	22,150	7,029	0	6,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	19,803	1,197	1,668	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	110,985	117,012	154,278	347,852	89,539	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	180	0	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	6	0	0	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	9	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
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)	111,180	117,012	154,278	347,852	89,539	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	17,960				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,922	1,204,200	0	1,204,200	30.00
31.00	03100	INTENSIVE CARE UNIT	2,520	152,086	0	152,086	31.00
43.00	04300	NURSERY	1,518	79,054	0	79,054	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,123,079	0	1,123,079	50.00
53.00	05300	ANESTHESIOLOGY	0	5,595	0	5,595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	479,794	0	479,794	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	856,821	0	856,821	55.00
57.00	05700	CT SCAN	0	59,000	0	59,000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	285,771	0	285,771	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	132,106	0	132,106	59.00
60.00	06000	LABORATORY	0	812,726	0	812,726	60.00
65.00	06500	RESPIRATORY THERAPY	0	342,533	0	342,533	65.00
66.00	06600	PHYSICAL THERAPY	0	554,460	0	554,460	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	164,147	0	164,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	179,807	0	179,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	200,837	0	200,837	73.00
76.97	07697	CARDIAC REHABILITATION	0	210,012	0	210,012	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	110,600	0	110,600	90.01
91.00	09100	EMERGENCY	0	359,631	0	359,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	604,204	0	604,204	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,960	7,916,463	0	7,916,463	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,849	0	21,849	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	432,479	0	432,479	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	1,928	0	1,928	192.01
194.00	07950	CROSSTOWN SQUARE	0	55	0	55	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	12,763	0	12,763	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	9,556	0	9,556	194.03
194.04	07951	OUTREACH	0	168	0	168	194.04
194.05	07956	RETAIL PHARMACY	0	35,584	0	35,584	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,960	8,430,845	0	8,430,845	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	230,211				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,901,473			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	24,925,285		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,750	123,878	2,295,927	-19,866,925	5.00
7.00	00700	OPERATION OF PLANT	21,729	51,697	566,969	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	0	38,726	0	8.00
9.00	00900	HOUSEKEEPING	1,092	19,205	0	0	9.00
10.00	01000	DIETARY	5,281	9,625	0	0	10.00
11.00	01100	CAFETERIA	2,932	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	780	49,526	820,694	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	19,566	104,544	0	14.00
15.00	01500	PHARMACY	4,640	69,792	1,830,583	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,014	122,657	3,680,356	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	22,407	678,426	0	31.00
43.00	04300	NURSERY	2,169	19,968	295,996	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,107	466,076	1,680,582	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,253	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	221,672	1,020,138	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,245	1,016,061	0	55.00
57.00	05700	CT SCAN	0	9,038	252,038	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	245,323	122,786	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	33,732	451,734	0	59.00
60.00	06000	LABORATORY	14,984	37,154	2,263,550	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	102,930	1,126,391	0	65.00
66.00	06600	PHYSICAL THERAPY	3,386	23,586	1,399,229	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72,784	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	8,700	628	264,783	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	1,893	9,335	238,551	0	90.01
91.00	09100	EMERGENCY	8,836	30,236	2,014,592	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	7,101	112,749	2,737,048	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,892	1,894,062	24,899,704	-19,866,925	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	91	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	7,320	24,332	0	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	485	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	764	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	194.05
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)	2,127,738	1,969,974	1,838,569	19,866,925	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.242556	1.036025	0.073763	0.316370	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,176	2,823,405	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000208	0.044961	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: 14-0275

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	154,172				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	379,302			8.00
9.00	00900	HOUSEKEEPING	1,092	0	141,266		9.00
10.00	01000	DIETARY	5,281	0	5,281	79,621	10.00
11.00	01100	CAFETERIA	2,932	0	2,932	47,669	35,275 11.00
13.00	01300	NURSING ADMINISTRATION	780	0	780	0	1,081 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	3,339	6,688	0	298 14.00
15.00	01500	PHARMACY	4,640	0	4,640	0	1,970 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	2,752	0	0 16.00
17.00	01700	SOCIAL SERVICE	1,104	0	1,104	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,014	96,865	43,014	27,943	4,997 30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	21,410	3,740	4,009	895 31.00
43.00	04300	NURSERY	2,169	9,743	2,169	0	1,155 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,107	93,514	16,107	0	2,550 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	34,995	8,858	0	1,672 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	1,723 55.00
57.00	05700	CT SCAN	0	18,579	0	0	386 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	4,238	182	0	168 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	6,926	2,408	0	358 59.00
60.00	06000	LABORATORY	14,984	70	14,984	0	4,500 60.00
65.00	06500	RESPIRATORY THERAPY	2,812	2,846	2,812	0	1,808 65.00
66.00	06600	PHYSICAL THERAPY	3,386	5,899	3,386	0	1,990 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	8,700	185	8,700	0	395 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	WOUND CENTER	1,893	1,018	1,893	0	269 90.01
91.00	09100	EMERGENCY	8,836	79,675	8,836	0	2,715 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	7,101	0	0	0	6,283 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	151,853	379,302	141,266	79,621	35,213 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	0	0	57 192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	0	0 192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	2 194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	0 194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0 194.03
194.04	07951	OUTREACH	0	0	0	0	3 194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,343,393	194,822	1,064,980	1,036,268	741,773 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.686123	0.513633	7.538827	13.015009	21.028292 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	537,957	35,369	69,366	118,911	111,180 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.489330	0.093248	0.491031	1.493463	3.151807 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: 14-0275

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

Worksheet B-1

Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	258,361				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,108,455			14.00
15.00	01500	PHARMACY	0	127,459	12,461,676		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	290,605,470	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	110,326	356,887	0	19,838,204	30.00
31.00	03100	INTENSIVE CARE UNIT	17,461	108,483	0	4,688,364	31.00
43.00	04300	NURSERY	7,995	29,137	0	699,636	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	36,990	763,516	0	20,934,615	50.00
53.00	05300	ANESTHESIOLOGY	0	32,564	0	2,753,923	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	548	35,767	0	12,313,299	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19,804	205,105	9,656,604	55,648,092	55.00
57.00	05700	CT SCAN	10	105,475	0	29,301,907	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4	4,931	0	6,008,323	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,647	82,495	0	9,277,614	59.00
60.00	06000	LABORATORY	2,147	30,697	0	50,796,757	60.00
65.00	06500	RESPIRATORY THERAPY	59	119,392	0	13,871,422	65.00
66.00	06600	PHYSICAL THERAPY	0	10,169	0	6,949,171	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,189,495	0	4,361,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,521,464	0	8,936,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,805,072	18,898,331	73.00
76.97	07697	CARDIAC REHABILITATION	2,486	4,515	0	869,774	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	5,336	36,560	0	3,056,159	90.01
91.00	09100	EMERGENCY	48,906	278,294	0	21,401,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,642	66,050	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,361	6,108,455	12,461,676	290,605,470	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE BUILDING	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	194.00
194.02	07954	NONALLOW PHYSICIAN MEALS	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,415,006	1,071,113	3,556,038	1,636,516	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.476856	0.175349	0.285358	0.005631	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	117,012	154,278	347,852	89,539	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.452901	0.025256	0.027914	0.000308	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 9:22 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,240,573		10,240,573	0	10,240,573	30.00
31.00	03100	INTENSIVE CARE UNIT	1,741,311		1,741,311	0	1,741,311	31.00
43.00	04300	NURSERY	712,437		712,437	0	712,437	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,969,552		5,969,552	0	5,969,552	50.00
53.00	05300	ANESTHESIOLOGY	67,795		67,795	0	67,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,601,327		3,601,327	0	3,601,327	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	18,162,321		18,162,321	0	18,162,321	55.00
57.00	05700	CT SCAN	866,429		866,429	0	866,429	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	667,328		667,328	0	667,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,765,567		1,765,567	0	1,765,567	59.00
60.00	06000	LABORATORY	10,343,807		10,343,807	0	10,343,807	60.00
65.00	06500	RESPIRATORY THERAPY	2,508,967	0	2,508,967	0	2,508,967	65.00
66.00	06600	PHYSICAL THERAPY	2,856,748	0	2,856,748	0	2,856,748	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,912,410		1,912,410	0	1,912,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,811,639		3,811,639	0	3,811,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,324,062		4,324,062	0	4,324,062	73.00
76.97	07697	CARDIAC REHABILITATION	894,571		894,571	0	894,571	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CENTER	663,378		663,378	0	663,378	90.01
91.00	09100	EMERGENCY	4,471,846		4,471,846	0	4,471,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,129,608		2,129,608		2,129,608	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,308,942		4,308,942	20	4,308,962	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	82,020,618	0	82,020,618	20	82,020,638	200.00
201.00		Less Observation Beds	2,129,608		2,129,608		2,129,608	201.00
202.00		Total (see instructions)	79,891,010	0	79,891,010	20	79,891,030	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 9:22 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	15,676,817		15,676,817		30.00
31.00	03100	INTENSIVE CARE UNIT	4,688,364		4,688,364		31.00
43.00	04300	NURSERY	699,636		699,636		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,303,227	15,631,388	20,934,615	0.285152	0.000000
53.00	05300	ANESTHESIOLOGY	802,034	1,951,889	2,753,923	0.024618	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,199,746	11,113,553	12,313,299	0.292475	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	83,372	55,564,720	55,648,092	0.326378	0.000000
57.00	05700	CT SCAN	4,909,197	24,392,710	29,301,907	0.029569	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	346,880	5,661,443	6,008,323	0.111067	0.000000
59.00	05900	CARDIAC CATHETERIZATION	2,988,117	6,289,497	9,277,614	0.190304	0.000000
60.00	06000	LABORATORY	8,037,007	42,759,750	50,796,757	0.203631	0.000000
65.00	06500	RESPIRATORY THERAPY	6,330,585	7,540,837	13,871,422	0.180873	0.000000
66.00	06600	PHYSICAL THERAPY	756,515	6,192,656	6,949,171	0.411092	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,641,845	2,719,783	4,361,628	0.438462	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,190,764	4,746,059	8,936,823	0.426509	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	12,635,806	6,262,525	18,898,331	0.228807	0.000000
76.97	07697	CARDIAC REHABILITATION	15,944	853,830	869,774	1.028510	0.000000
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
90.01	09001	WOUND CENTER	23,331	3,032,828	3,056,159	0.217063	0.000000
91.00	09100	EMERGENCY	3,316,498	18,084,930	21,401,428	0.208951	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,746	3,984,641	4,161,387	0.511754	0.000000
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,039,321	11,039,321	0.390327	0.000000
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	73,822,431	227,822,360	301,644,791		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	73,822,431	227,822,360	301,644,791		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 9:22 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
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.285152			50.00
53.00	05300	ANESTHESIOLOGY	0.024618			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.292475			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.326378			55.00
57.00	05700	CT SCAN	0.029569			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.111067			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190304			59.00
60.00	06000	LABORATORY	0.203631			60.00
65.00	06500	RESPIRATORY THERAPY	0.180873			65.00
66.00	06600	PHYSICAL THERAPY	0.411092			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438462			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.426509			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228807			73.00
76.97	07697	CARDIAC REHABILITATION	1.028510			76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CENTER	0.217063			90.01
91.00	09100	EMERGENCY	0.208951			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.511754			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.390329			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 9:22 am

			Title XIX		Hospital			
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,240,573		10,240,573	0	10,240,573	30.00
31.00	03100	INTENSIVE CARE UNIT	1,741,311		1,741,311	0	1,741,311	31.00
43.00	04300	NURSERY	712,437		712,437	0	712,437	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,969,552		5,969,552	0	5,969,552	50.00
53.00	05300	ANESTHESIOLOGY	67,795		67,795	0	67,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,601,327		3,601,327	0	3,601,327	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	18,162,321		18,162,321	0	18,162,321	55.00
57.00	05700	CT SCAN	866,429		866,429	0	866,429	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	667,328		667,328	0	667,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,765,567		1,765,567	0	1,765,567	59.00
60.00	06000	LABORATORY	10,343,807		10,343,807	0	10,343,807	60.00
65.00	06500	RESPIRATORY THERAPY	2,508,967	0	2,508,967	0	2,508,967	65.00
66.00	06600	PHYSICAL THERAPY	2,856,748	0	2,856,748	0	2,856,748	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,912,410		1,912,410	0	1,912,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,811,639		3,811,639	0	3,811,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,324,062		4,324,062	0	4,324,062	73.00
76.97	07697	CARDIAC REHABILITATION	894,571		894,571	0	894,571	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CENTER	663,378		663,378	0	663,378	90.01
91.00	09100	EMERGENCY	4,471,846		4,471,846	0	4,471,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,129,608		2,129,608		2,129,608	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,308,942		4,308,942	20	4,308,962	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	82,020,618	0	82,020,618	20	82,020,638	200.00
201.00		Less Observation Beds	2,129,608		2,129,608		2,129,608	201.00
202.00		Total (see instructions)	79,891,010	0	79,891,010	20	79,891,030	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 9:22 am

			Title XIX		Hospital		11/23/2021 9:22 am	
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	15,676,817		15,676,817			30.00
31.00	03100	INTENSIVE CARE UNIT	4,688,364		4,688,364			31.00
43.00	04300	NURSERY	699,636		699,636			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,303,227	15,631,388	20,934,615	0.285152	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	802,034	1,951,889	2,753,923	0.024618	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,199,746	11,113,553	12,313,299	0.292475	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	83,372	55,564,720	55,648,092	0.326378	0.000000	55.00
57.00	05700	CT SCAN	4,909,197	24,392,710	29,301,907	0.029569	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	346,880	5,661,443	6,008,323	0.111067	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,988,117	6,289,497	9,277,614	0.190304	0.000000	59.00
60.00	06000	LABORATORY	8,037,007	42,759,750	50,796,757	0.203631	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,330,585	7,540,837	13,871,422	0.180873	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	756,515	6,192,656	6,949,171	0.411092	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,641,845	2,719,783	4,361,628	0.438462	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,190,764	4,746,059	8,936,823	0.426509	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,635,806	6,262,525	18,898,331	0.228807	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	15,944	853,830	869,774	1.028510	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CENTER	23,331	3,032,828	3,056,159	0.217063	0.000000	90.01
91.00	09100	EMERGENCY	3,316,498	18,084,930	21,401,428	0.208951	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,746	3,984,641	4,161,387	0.511754	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,039,321	11,039,321	0.390327	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	73,822,431	227,822,360	301,644,791			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	73,822,431	227,822,360	301,644,791			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CENTER	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part I Date/Time Prepared: 11/23/2021 9:22 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	1,204,200	0	1,204,200	9,877	121.92		30.00	
31.00	INTENSIVE CARE UNIT	152,086		152,086	1,474	103.18		31.00	
43.00	NURSERY	79,054		79,054	888	89.02		43.00	
200.00	Total (lines 30 through 199)	1,435,340		1,435,340	12,239			200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)						
		6.00	7.00						
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,472	301,386						30.00
31.00	INTENSIVE CARE UNIT	579	59,741						31.00
43.00	NURSERY	0	0						43.00
200.00	Total (lines 30 through 199)	3,051	361,127						200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/23/2021 9:22 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	1,123,079	20,934,615	0.053647	2,118,489	113,651	50.00
53.00	05300	ANESTHESIOLOGY	5,595	2,753,923	0.002032	252,478	513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,794	12,313,299	0.038966	460,395	17,940	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	856,821	55,648,092	0.015397	29,117	448	55.00
57.00	05700	CT SCAN	59,000	29,301,907	0.002014	1,819,316	3,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	285,771	6,008,323	0.047563	99,852	4,749	58.00
59.00	05900	CARDIAC CATHETERIZATION	132,106	9,277,614	0.014239	536,147	7,634	59.00
60.00	06000	LABORATORY	812,726	50,796,757	0.016000	2,713,480	43,416	60.00
65.00	06500	RESPIRATORY THERAPY	342,533	13,871,422	0.024693	1,861,525	45,967	65.00
66.00	06600	PHYSICAL THERAPY	554,460	6,949,171	0.079788	321,761	25,673	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	164,147	4,361,628	0.037634	1,168,924	43,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	179,807	8,936,823	0.020120	1,827,226	36,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	200,837	18,898,331	0.010627	4,305,030	45,750	73.00
76.97	07697	CARDIAC REHABILITATION	210,012	869,774	0.241456	5,036	1,216	76.97
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CENTER	110,600	3,056,159	0.036189	6,548	237	90.01
91.00	09100	EMERGENCY	359,631	21,401,428	0.016804	1,634,125	27,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,423	4,161,387	0.060178	176,746	10,636	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,127,342	269,540,653		19,336,195	429,709	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/23/2021 9:22 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	9,877	0.00	2,472		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,474	0.00	579		31.00	
43.00	04300	NURSERY			0	888	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	12,239		3,051		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0275

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 9:22 am

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	20,934,615	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,753,923	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,313,299	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55,648,092	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	29,301,907	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	6,008,323	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	9,277,614	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	50,796,757	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,871,422	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,949,171	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,361,628	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,936,823	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,898,331	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	869,774	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CENTER	0	0	0	3,056,159	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	21,401,428	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,161,387	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	269,540,653		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0275

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

Worksheet D
Part IV
Date/Time Prepared:
11/23/2021 9:22 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	2,118,489	0	5,006,836	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	252,478	0	373,636	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	460,395	0	3,911,414	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	29,117	0	20,144,745	0	55.00
57.00	05700	CT SCAN	0.000000	1,819,316	0	5,549,781	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	99,852	0	1,315,569	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	536,147	0	350,326	0	59.00
60.00	06000	LABORATORY	0.000000	2,713,480	0	2,521,020	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,861,525	0	1,662,589	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	321,761	0	23,699	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,168,924	0	851,686	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,827,226	0	1,311,631	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,305,030	0	2,890,444	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	5,036	0	357,512	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0.000000	6,548	0	559,245	0	90.01
91.00	09100	EMERGENCY	0.000000	1,634,125	0	3,837,626	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	176,746	0	822,236	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		19,336,195	0	51,489,995	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 9:22 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		0.285152	5,006,836	0	0	1,427,709	50.00
53.00	05300	ANESTHESIOLOGY		0.024618	373,636	0	0	9,198	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.292475	3,911,414	0	0	1,143,991	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.326378	20,144,745	0	0	6,574,802	55.00
57.00	05700	CT SCAN		0.029569	5,549,781	0	0	164,101	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.111067	1,315,569	0	0	146,116	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.190304	350,326	0	0	66,668	59.00
60.00	06000	LABORATORY		0.203631	2,521,020	2,310	0	513,358	60.00
65.00	06500	RESPIRATORY THERAPY		0.180873	1,662,589	0	0	300,717	65.00
66.00	06600	PHYSICAL THERAPY		0.411092	23,699	0	0	9,742	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.438462	851,686	0	0	373,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.426509	1,311,631	0	0	559,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.228807	2,890,444	0	11,878	661,354	73.00
76.97	07697	CARDIAC REHABILITATION		1.028510	357,512	0	0	367,705	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CENTER		0.217063	559,245	0	0	121,391	90.01
91.00	09100	EMERGENCY		0.208951	3,837,626	0	0	801,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.511754	822,236	0	0	420,783	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0.390327		0			95.00
200.00		Subtotal (see instructions)			51,489,995	2,310	11,878	13,662,365	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			51,489,995	2,310	11,878	13,662,365	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0275		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/23/2021 9:22 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
53.00	05300	ANESTHESIOLOGY		0		0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0		0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0		0			55.00
57.00	05700	CT SCAN		0		0			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0		0			58.00
59.00	05900	CARDIAC CATHETERIZATION		0		0			59.00
60.00	06000	LABORATORY	470			0			60.00
65.00	06500	RESPIRATORY THERAPY		0		0			65.00
66.00	06600	PHYSICAL THERAPY		0		0			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0		0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0		2,718			73.00
76.97	07697	CARDIAC REHABILITATION		0		0			76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0		0			90.00
90.01	09001	WOUND CENTER		0		0			90.01
91.00	09100	EMERGENCY		0		0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0			92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0					95.00
200.00		Subtotal (see instructions)	470			2,718			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	470			2,718			202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/23/2021 9:22 am	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			9,877	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			9,877	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			7,823	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)			2,472	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)			10,240,573	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)			10,240,573	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)			10,240,573	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,036.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,562,994	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)			2,562,994	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0275

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	1,741,311	1,474	1,181.35	579	684,002
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,658,283
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,905,279
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					361,127
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					429,709
52.00	Total Program excludable cost (sum of lines 50 and 51)					790,836
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,114,443
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					2,054
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,036.81
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,129,608

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0275

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

Worksheet D-1

Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,204,200	10,240,573	0.117591	2,129,608	250,423
91.00	Nursing School cost	0	10,240,573	0.000000	2,129,608	0
92.00	Allied health cost	0	10,240,573	0.000000	2,129,608	0
93.00	All other Medical Education	0	10,240,573	0.000000	2,129,608	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/23/2021 9:22 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,321,110	30.00
31.00	03100	INTENSIVE CARE UNIT		1,663,502	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.285152	2,118,489	50.00
53.00	05300	ANESTHESIOLOGY	0.024618	252,478	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.292475	460,395	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.326378	29,117	55.00
57.00	05700	CT SCAN	0.029569	1,819,316	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.111067	99,852	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.190304	536,147	59.00
60.00	06000	LABORATORY	0.203631	2,713,480	60.00
65.00	06500	RESPIRATORY THERAPY	0.180873	1,861,525	65.00
66.00	06600	PHYSICAL THERAPY	0.411092	321,761	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.438462	1,168,924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.426509	1,827,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.228807	4,305,030	73.00
76.97	07697	CARDIAC REHABILITATION	1.028510	5,036	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CENTER	0.217063	6,548	90.01
91.00	09100	EMERGENCY	0.208951	1,634,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.511754	176,746	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,336,195	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)		19,336,195	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 9:22 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)		1,812,724	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,438,173	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		31,047	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		139.37	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.75	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.14	31.00
32.00	Sum of lines 30 and 31		28.89	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.05	33.00
34.00	Disproportionate share adjustment (see instructions)		236,561	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 9:22 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)	641,601	685,085		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	161,277	512,406		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	673,683			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	8,192,188			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)		8,192,188		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		581,821		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		117,076		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)		8,891,085		59.00
60.00	Primary payer payments		14,057		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,877,028		61.00
62.00	Deductibles billed to program beneficiaries		911,972		62.00
63.00	Coinsurance billed to program beneficiaries		3,520		63.00
64.00	Allowable bad debts (see instructions)		183,211		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		119,087		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		147,732		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,080,623		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		82,731		70.93
70.94	HRR adjustment amount (see instructions)		-41,615		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/23/2021 9:22 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)		8,121,739	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		7,862,540	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)		259,199	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		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

Health Financial Systems		GENESIS MEDICAL CENTER - SILVIS		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 9:22 am	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			3,188	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			13,662,365	2.00
3.00	OPPS payments			11,310,834	3.00
4.00	Outlier payment (see instructions)			13,549	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,188	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			14,188	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)			14,188	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)			14,188	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			11,000	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			3,188	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)			11,324,383	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			336	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			2,093,103	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)			9,234,132	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)			9,234,132	30.00
31.00	Primary payer payments			3,738	31.00
32.00	Subtotal (line 30 minus line 31)			9,230,394	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)			271,082	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			176,203	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			212,970	36.00
37.00	Subtotal (see instructions)			9,406,597	37.00
38.00	MSP-LCC reconciliation amount from PS&R			-93	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)			9,406,690	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			9,424,724	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)			-18,034	43.00
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/23/2021 9:22 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		7,862,540		9,378,224	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	01/06/2021	46,500	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		46,500	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)		7,862,540		9,424,724	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		259,199		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		18,034	6.02	
7.00	Total Medicare program liability (see instructions)		8,121,739		9,406,690	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/23/2021 9:22 am

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

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

Provider CCN: 14-0275

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

Worksheet G

Date/Time Prepared:

11/23/2021 9:22 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	66,718,827	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	1,966,489	0	0	0	3.00
4.00 Accounts receivable	45,139,463	0	0	0	4.00
5.00 Other receivable	245,678	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-30,047,372	0	0	0	6.00
7.00 Inventory	3,435,621	0	0	0	7.00
8.00 Prepaid expenses	517,046	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	7,847,481	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	95,823,233	0	0	0	11.00
FIXED ASSETS					
12.00 Land	2,304,399	0	0	0	12.00
13.00 Land improvements	5,170,526	0	0	0	13.00
14.00 Accumulated depreciation	-2,605,979	0	0	0	14.00
15.00 Buildings	56,185,761	0	0	0	15.00
16.00 Accumulated depreciation	-37,840,732	0	0	0	16.00
17.00 Leasehold improvements	2,115,300	0	0	0	17.00
18.00 Accumulated depreciation	-920,878	0	0	0	18.00
19.00 Fixed equipment	1,023,362	0	0	0	19.00
20.00 Accumulated depreciation	-375,081	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	53,937,504	0	0	0	23.00
24.00 Accumulated depreciation	-47,340,804	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	644,107	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	32,297,485	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	9,715,970	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	9,715,970	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	137,836,688	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,708,712	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,346,485	0	0	0	38.00
39.00 Payroll taxes payable	499,877	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,056,008	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	21,394,357	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	27,005,439	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	623,076	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	3,153,855	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	3,776,931	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	30,782,370	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	107,054,318	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	107,054,318	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	137,836,688	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0275

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

Worksheet G-1

Date/Time Prepared:
11/23/2021 9:22 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		101,031,829		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,537,425				2.00
3.00	Total (sum of line 1 and line 2)		106,569,254		0		3.00
4.00	ADDITIONS	159,671		0		0	4.00
5.00	RESTRICTED ASSETS	325,393		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)		485,064		0		10.00
11.00	Subtotal (line 3 plus line 10)		107,054,318		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)		107,054,318		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		0				4.00
5.00	RESTRICTED ASSETS		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: 14-0275

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/23/2021 9:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,515,547		16,515,547	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,515,547		16,515,547	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,703,525		4,703,525	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,703,525		4,703,525	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,219,072		21,219,072	17.00
18.00	Ancillary services	49,495,672	193,675,940	243,171,612	18.00
19.00	Outpatient services	3,526,945	25,312,561	28,839,506	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	11,039,321	11,039,321	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	1,529,392	9,152,870	10,682,262	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	75,771,081	239,180,692	314,951,773	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,960,511		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)		98,960,511		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0275

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

Worksheet G-3

Date/Time Prepared:
11/23/2021 9:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	314,951,773	1.00
2.00	Less contractual allowances and discounts on patients' accounts	216,343,024	2.00
3.00	Net patient revenues (line 1 minus line 2)	98,608,749	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,960,511	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-351,762	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	5,024,612	24.00
24.01	OTHER (SPECIFY)	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	NONOPERATING GAINS & LOSSES	539,575	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.50	COVID-19 PHE Funding	325,000	24.50
25.00	Total other income (sum of lines 6-24)	5,889,187	25.00
26.00	Total (line 5 plus line 25)	5,537,425	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)	5,537,425	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0275	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/23/2021 9:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		545,725	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,243	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)		26.12	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.75	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		25.14	8.00
9.00	Sum of lines 7 and 8		28.89	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.02	10.00
11.00	Disproportionate share adjustment (see instructions)		32,853	11.00
12.00	Total prospective capital payments (see instructions)		581,821	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