

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/31/2022 9:38 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/31/2022	Time: 9:38 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ANDERSON HOSPITAL (14-0289) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	390,133	-93,389	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	9,164	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	399,297	-93,389	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: 14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:38 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 6800 STATE ROUTE 162			PO Box:		1.00			
2.00	City: MARYVILLE			State: IL		Zip Code: 62062-1000		County: MADISON	
		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			ANDERSON HOSPITAL	140289	41180	1	11/22/1976	N
4.00	Subprovider - IPF							P	N
5.00	Subprovider - IRF			THE REHABILITATION CENTER	14T289	41180	5	01/01/2005	N
6.00	Subprovider - (Other)							P	N
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA			ANDERSON HOME HEALTH	147420	41180	05/30/1985	N	P
13.00	Separately Certified ASC								N
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021	
21.00	Type of Control (see instructions)						2		
							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		
22.01	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		
22.02	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		
22.03	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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:38 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	805	1,231	0	0	3,501	226	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	19	65	0	0	81		25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:38 am	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
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
62.01	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/31/2022 9:38 am

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			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.	N	N		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:38 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			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.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			1,005,750	0		0118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			N			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:38 am		
			1.00	2.00					
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		HB0972		140.00	
			1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: ANDERSON HEALTHCARE		Contractor's Name: NGS		Contractor's Number: 06101				141.00
142.00	Street: 6800 STATE ROUTE 162		PO Box:						142.00
143.00	City: MARYVILLE		State: IL		Zip Code: 62062				143.00
					1.00				
144.00	Are provider based physicians' costs included in Worksheet A?				Y			144.00	
					1.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00	
					1.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N			149.00	
			Part A	Part B	Title V	Title XIX			
			1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital		N	N	N	N		155.00	
156.00	Subprovider - IPF		N	N	N	N		156.00	
157.00	Subprovider - IRF		N	N	N	N		157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF		N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY		N	N	N	N		160.00	
161.00	CMHC			N	N	N		161.00	
					1.00				
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N			165.00	
			Name	County	State	Zip Code	CBSA	FTE/Campus	
			0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	
					1.00				
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y			167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 9:38 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 9:38 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	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 a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/12/2022	Y	04/12/2022		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part II
Date/Time Prepared:
5/31/2022 9:38 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 9:38 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR		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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 9:38 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	108	37,290	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)		108	37,290	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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)		120	41,670	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	4,260		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		120				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 9:38 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,276	640	21,224		1.00
2.00	HMO and other (see instructions)	5,943	4,732			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	374	146			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,276	640	21,224		7.00
8.00	INTENSIVE CARE UNIT	831	77	2,529		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		88	2,898		13.00
14.00	Total (see instructions)	8,107	805	26,651	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF	838	19	1,476	0.00	17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	3,617	0	8,819	0.00	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	26.25
27.00	Total (sum of lines 14-26)				0.00	916.00
28.00	Observation Bed Days		708	4,056		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	226	492		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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 9:38 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,718	179	6,273	1.00
2.00 HMO and other (see instructions)			1,204	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	1,718	179	6,273	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	72	1	132	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	0.00					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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/31/2022 9:38 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	59,840,426	-38,397	59,802,029	1,905,241.01	31.39 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		6,158,417	0	6,158,417	202,477.00	30.42 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		1,880,726	0	1,880,726	53,380.00	35.23 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		826,545	0	826,545	5,466.99	151.19 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		403,933	0	403,933	2,080.50	194.15 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		7,234,713	0	7,234,713	224,456.56	32.23 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,982,215	0	10,982,215		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		337,828	0	337,828		
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)		1,463,383	0	1,463,383		
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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/31/2022 9:38 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	385,304	0	385,304	12,237.00	31.49	26.00
27.00	Administrative & General	5.00	8,808,324	-329,146	8,479,178	302,254.00	28.05	27.00
28.00	Administrative & General under contract (see inst.)		929,698	0	929,698	6,234.72	149.12	28.00
29.00	Maintenance & Repairs	6.00	1,058,686	0	1,058,686	35,289.00	30.00	29.00
30.00	Operation of Plant	7.00	38,397	-38,397	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	69,193	0	69,193	4,172.00	16.59	31.00
32.00	Housekeeping	9.00	1,510,772	0	1,510,772	81,809.00	18.47	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	930,142	-599,121	331,021	18,818.01	17.59	34.00
35.00	Dietary under contract (see instructions)		1,411,788	0	1,411,788	99,282.00	14.22	35.00
36.00	Cafeteria	11.00	0	599,121	599,121	34,058.99	17.59	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	682,422	0	682,422	14,437.00	47.27	38.00
39.00	Central Services and Supply	14.00	929,555	0	929,555	45,437.00	20.46	39.00
40.00	Pharmacy	15.00	1,872,342	0	1,872,342	42,354.00	44.21	40.00
41.00	Medical Records & Medical Records Library	16.00	1,186,272	0	1,186,272	54,709.00	21.68	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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/31/2022 9:38 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	56,023,495	-38,397	55,985,098	1,808,280.73	30.96	1.00
2.00	Excluded area salaries (see instructions)	1,880,726	0	1,880,726	53,380.00	35.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,142,769	-38,397	54,104,372	1,754,900.73	30.83	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,465,191	0	8,465,191	232,004.05	36.49	4.00
5.00	Subtotal wage-related costs (see inst.)	12,445,598	0	12,445,598	0.00	23.00	5.00
6.00	Total (sum of lines 3 thru 5)	75,053,558	-38,397	75,015,161	1,986,904.78	37.75	6.00
7.00	Total overhead cost (see instructions)	19,812,895	-367,543	19,445,352	751,091.72	25.89	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/31/2022 9:38 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,352,012	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	1,565	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)	4,389,766	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	178,443	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	54,581	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	107,899	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	20,379	14.00
15.00	'Workers' Compensation Insurance	623,144	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,454,573	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	53,860	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	83,820	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,320,042	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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	826,545	11,320,042	1.00
2.00	Hospital	826,545	11,320,042	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0289 Component CCN: 14-7420		Period: From 01/01/2021 To 12/31/2021		Worksheet S-4 Date/Time Prepared: 5/31/2022 9:38 am	
						Home Health Agency I		PPS	
						1.00			
0.00	County							0.00	
				Title V	Title XVIII	Title XIX	Other	Total	
				1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA									
1.00	Home Health Aide Hours			0	60	6	77	143	1.00
2.00	Unduplicated Census Count (see instructions)			0.00	231.00	25.00	336.00	0.00	2.00
				Number of Employees (Full Time Equivalent)					
				Enter the number of hours in your normal work week					
				Staff		Contract		Total	
				0		1.00		2.00	
				1.00		2.00		3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES									
3.00	Administrator and Assistant Administrator(s)			0.00	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel				4.80	0.00	0.00	4.80	5.00
6.00	Direct Nursing Service				9.30	0.00	0.00	9.30	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				3.25	0.00	0.00	3.25	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				2.25	0.00	0.00	2.25	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				0.28	0.00	0.00	0.28	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	0.00	13.00
14.00	Medical Social Service				0.00	0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	0.00	15.00
16.00	Home Health Aide				0.07	0.00	0.00	0.07	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	0.00	17.00
18.00	MANAGER				1.00	0.00	0.00	1.00	18.00
								CBSA Data	
								1.00	
HOME HEALTH AGENCY CBSA CODES									
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.							2	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).							41180	20.00
20.01								44100	20.01
				Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
				Without Outliers	With Outliers				
				1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA									
21.00	Skilled Nursing Visits			1,578	294	76	0	1,948	21.00
22.00	Skilled Nursing Visit Charges			313,340	58,325	15,135	0	386,800	22.00
23.00	Physical Therapy Visits			824	223	15	0	1,062	23.00
24.00	Physical Therapy Visit Charges			163,901	44,343	2,992	0	211,236	24.00
25.00	Occupational Therapy Visits			356	184	8	0	548	25.00
26.00	Occupational Therapy Visit Charges			70,826	36,660	1,592	0	109,078	26.00
27.00	Speech Pathology Visits			25	18	3	0	46	27.00
28.00	Speech Pathology Visit Charges			4,932	3,600	600	0	9,132	28.00
29.00	Medical Social Service Visits			0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges			0	0	0	0	0	30.00
31.00	Home Health Aide Visits			9	3	1	0	13	31.00
32.00	Home Health Aide Visit Charges			884	306	102	0	1,292	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)			2,792	722	103	0	3,617	33.00
34.00	Other Charges			0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)			553,883	143,234	20,421	0	717,538	35.00
36.00	Total Number of Episodes (standard/non outlier)			342		61	0	403	36.00
37.00	Total Number of Outlier Episodes				39		0	39	37.00
38.00	Total Non-Routine Medical Supply Charges			20,196	1,430	1,365	0	22,991	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/31/2022 9:38 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.199671 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	16,039,358		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	106,806,653		6.00
7.00	Medicaid cost (line 1 times line 6)	21,326,191		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)	5,286,833		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)	5,286,833		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)	8,176,742	3,309,627	11,486,369 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,632,658	3,309,627	4,942,285 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	1,632,658	3,309,627	4,942,285 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)	8,567,260		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	332,656		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	511,779		27.01
28.00	Non-Medicare bad debt expense (see instructions)	8,055,481		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,787,569		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,729,854		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,016,687		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,129,544	3,129,544	1,250,979	4,380,523	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,115,659	4,115,659	404,324	4,519,983	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	385,304	13,202,426	13,587,730	1,565	13,589,295	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,808,324	28,517,601	37,325,925	-1,242,694	36,083,231	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,058,686	953,940	2,012,626	-2,713	2,009,913	6.00
7.00	00700	OPERATION OF PLANT	38,397	2,078,863	2,117,260	49,093	2,166,353	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,193	517,414	586,607	0	586,607	8.00
9.00	00900	HOUSEKEEPING	1,510,772	264,852	1,775,624	0	1,775,624	9.00
10.00	01000	DIETARY	930,142	1,156,866	2,087,008	-1,344,278	742,730	10.00
11.00	01100	CAFETERIA	0	0	0	1,344,278	1,344,278	11.00
13.00	01300	NURSING ADMINISTRATION	682,422	27,169	709,591	-8,168	701,423	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	929,555	669,362	1,598,917	-504,711	1,094,206	14.00
15.00	01500	PHARMACY	1,872,342	5,777,030	7,649,372	-83,145	7,566,227	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,186,272	144,809	1,331,081	-650	1,330,431	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	91,049	0	91,049	0	91,049	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,995,778	2,097,786	15,093,564	-3,629,364	11,464,200	30.00
31.00	03100	INTENSIVE CARE UNIT	2,591,864	497,346	3,089,210	-21,305	3,067,905	31.00
41.00	04100	SUBPROVIDER - IRF	497,826	272,533	770,359	-1,276	769,083	41.00
43.00	04300	NURSERY	0	0	0	1,349,662	1,349,662	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,938,569	9,833,036	15,771,605	-7,425,281	8,346,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,985,428	1,985,428	52.00
53.00	05300	ANESTHESIOLOGY	0	336,480	336,480	-41,559	294,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,451,195	1,532,745	3,983,940	89,850	4,073,790	54.00
56.00	05600	RADIOISOTOPE	155,730	264,107	419,837	-192,128	227,709	56.00
57.00	05700	CT SCAN	550,728	856,500	1,407,228	-197,814	1,209,414	57.00
58.00	05800	MRI	210,764	435,571	646,335	-52,338	593,997	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,005,972	1,275,093	2,281,065	-1,189,466	1,091,599	59.00
60.00	06000	LABORATORY	1,867,644	4,134,872	6,002,516	-6,613	5,995,903	60.00
65.00	06500	RESPIRATORY THERAPY	1,345,736	587,925	1,933,661	-198,212	1,735,449	65.00
66.00	06600	PHYSICAL THERAPY	1,289,314	115,084	1,404,398	129,580	1,533,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	788,730	5,802	794,532	106,463	900,995	67.00
68.00	06800	SPEECH PATHOLOGY	706,925	4,873	711,798	69,119	780,917	68.00
68.01	03040	AUDIOLOGY	179,719	190,104	369,823	-159,180	210,643	68.01
69.00	06900	ELECTROCARDIOLOGY	553,589	192,065	745,654	-9,432	736,222	69.00
69.01	03160	CARDIOPULMONARY	656,058	380,875	1,036,933	-44,087	992,846	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	58,396	8,191	66,587	-5,742	60,845	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,961,081	10,961,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	8,168	8,168	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	863,021	8,720,316	9,583,337	-106,785	9,476,552	90.00
91.00	09100	EMERGENCY	6,278,559	1,809,061	8,087,620	-163,927	7,923,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,291,851	127,072	1,418,923	-27,636	1,391,287	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,091,086	1,091,086	-1,091,086	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,840,426	95,324,058	155,164,484	0	155,164,484	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	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	59,840,426	95,324,058	155,164,484	0	155,164,484	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0289

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

Worksheet A

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-784,063	3,596,460	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-307,023	4,212,960	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,262,767	12,326,528	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,226,756	24,856,475	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,009,913	6.00
7.00	00700	OPERATION OF PLANT	105,632	2,271,985	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	586,607	8.00
9.00	00900	HOUSEKEEPING	0	1,775,624	9.00
10.00	01000	DIETARY	0	742,730	10.00
11.00	01100	CAFETERIA	0	1,344,278	11.00
13.00	01300	NURSING ADMINISTRATION	194,731	896,154	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,094,206	14.00
15.00	01500	PHARMACY	0	7,566,227	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,424	1,483,855	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	91,049	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,391	11,458,809	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,067,905	31.00
41.00	04100	SUBPROVIDER - IRF	0	769,083	41.00
43.00	04300	NURSERY	0	1,349,662	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	8,346,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-19,789	1,965,639	52.00
53.00	05300	ANESTHESIOLOGY	-72,795	222,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,814	4,116,604	54.00
56.00	05600	RADIOISOTOPE	0	227,709	56.00
57.00	05700	CT SCAN	0	1,209,414	57.00
58.00	05800	MRI	0	593,997	58.00
59.00	05900	CARDIAC CATHETERIZATION	-15,760	1,075,839	59.00
60.00	06000	LABORATORY	0	5,995,903	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,735,449	65.00
66.00	06600	PHYSICAL THERAPY	0	1,533,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	900,995	67.00
68.00	06800	SPEECH PATHOLOGY	0	780,917	68.00
68.01	03040	AUDIOLOGY	-35,466	175,177	68.01
69.00	06900	ELECTROCARDIOLOGY	0	736,222	69.00
69.01	03160	CARDIOPULMONARY	-8,598	984,248	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	60,845	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,961,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	8,168	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-5,100	9,471,452	90.00
91.00	09100	EMERGENCY	-8,250	7,915,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,391,287	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,255,157	141,909,327	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,255,157	141,909,327	200.00

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
5/31/2022 9:38 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE TO CAPTL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	784,063		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	307,023		2.00
	TOTALS		0	1,091,086		
	B - TO RECLASS EXPENSES FOR CAFETERIA					
1.00	CAFETERIA	11.00	599,121	745,157		1.00
	TOTALS		599,121	745,157		
	C - L&D/NURSERY RECLASS					
1.00	NURSERY	43.00	1,259,039	150,866		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,852,114	221,932		2.00
	TOTALS		3,111,153	372,798		
	E - TO RECLASS ELECTRICITY EXP					
1.00	OPERATION OF PLANT	7.00	0	75,133		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	75,133		
	F - TO RECLASS TELEPHONE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,816		1.00
2.00	OPERATION OF PLANT	7.00	0	64		2.00
3.00	EMERGENCY	91.00	0	304		3.00
	TOTALS		0	2,184		
	G - TO RECLASS RENAL DIALYSIS EXP					
1.00	RENAL DIALYSIS	74.00	0	8,168		1.00
	TOTALS		0	8,168		
	H - INSURANCE EXPENSE					
1.00	OTHER CAP REL COSTS	3.00	0	176,553		1.00
	TOTALS		0	176,553		
	J - TO RECLASS MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,961,081		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
	TOTALS		0	10,961,081		
	K - TO RECLASS REAL ESTATE TAXES					
1.00	OTHER CAP REL COSTS	3.00	0	166,026		1.00
	TOTALS		0	166,026		
	L - TO RECLASS PHYSICIAN OFFICE LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	221,638		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	221,638		
	M - TO RECLASS PROF RENUMERATION					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	191,933		1.00
2.00	ANESTHESIOLOGY	53.00	0	175,000		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	12,000		3.00
	TOTALS		0	378,933		
	N - TO RECLASS PENSION AUDIT COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,565		1.00
	TOTALS		0	1,565		
	O - TO RECLASS REHAB ADMIN EXP					
1.00	SPEECH PATHOLOGY	68.00	64,167	5,102		1.00
2.00	AUDIOLOGY	68.01	18,699	1,487		2.00
3.00	OCCUPATIONAL THERAPY	67.00	98,688	7,847		3.00
4.00	PHYSICAL THERAPY	66.00	147,592	11,735		4.00

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
5/31/2022 9:38 am

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
TOTALS		329,146	26,171		
Q - TO RECLASS CABLE TB EXPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,593	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS		0	31,593		
S - PLANT OPERATIONS SALARIES					
1.00	OPERATION OF PLANT	7.00	0	38,397	1.00
TOTALS		0	38,397		
500.00	Grand Total: Increases	4,039,420	14,296,483		500.00

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
5/31/2022 9:38 am

	Decreases						5/31/2022 9:38 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE TO CAPTL						
1.00	INTEREST EXPENSE	113.00	0	1,091,086	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,091,086			
	B - TO RECLASS EXPENSES FOR CAFETERIA						
1.00	DIETARY	10.00	599,121	745,157	0		1.00
	TOTALS		599,121	745,157			
	C - L&D/NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	3,111,153	372,798	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		3,111,153	372,798			
	E - TO RECLASS ELECTRICITY EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23	0		1.00
2.00	CLINIC	90.00	0	75,110	0		2.00
	TOTALS		0	75,133			
	F - TO RECLASS TELEPHONE EXP						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	650	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	150	0		2.00
3.00	CLINIC	90.00	0	1,384	0		3.00
	TOTALS		0	2,184			
	G - TO RECLASS RENAL DIALYSIS EXP						
1.00	NURSING ADMINISTRATION	13.00	0	8,168	0		1.00
	TOTALS		0	8,168			
	H - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	176,553	12		1.00
	TOTALS		0	176,553			
	J - TO RECLASS MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	504,711	0		1.00
2.00	PHARMACY	15.00	0	83,145	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	157,413	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	21,305	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	1,276	0		5.00
6.00	NURSERY	43.00	0	60,243	0		6.00
7.00	OPERATING ROOM	50.00	0	7,425,281	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	88,618	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	216,559	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	102,083	0		10.00
11.00	RADIOISOTOPE	56.00	0	192,128	0		11.00
12.00	CT SCAN	57.00	0	197,814	0		12.00
13.00	MRI	58.00	0	52,338	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	1,189,466	0		14.00
15.00	LABORATORY	60.00	0	6,613	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	198,212	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	5,795	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	72	0		18.00
19.00	AUDIOLOGY	68.01	0	179,366	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	9,432	0		20.00
21.00	CARDIOPULMONARY	69.01	0	44,087	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,742	0		22.00
23.00	CLINIC	90.00	0	27,515	0		23.00
24.00	EMERGENCY	91.00	0	164,231	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	27,636	0		25.00
	TOTALS		0	10,961,081			
	K - TO RECLASS REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	166,026	0		1.00
	TOTALS		0	166,026			
	L - TO RECLASS PHYSICIAN OFFICE LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	197,686	10		1.00
2.00	PHYSICAL THERAPY	66.00	0	23,952	0		2.00
	TOTALS		0	221,638			
	M - TO RECLASS PROF RENUMERATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	378,933	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	378,933			
	N - TO RECLASS PENSION AUDIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,565	0		1.00
	TOTALS		0	1,565			
	O - TO RECLASS REHAB ADMIN EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	329,146	26,171	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		329,146	26,171			

RECLASSIFICATIONS

Provider CCN: 14-0289

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

Worksheet A-6

Date/Time Prepared:
5/31/2022 9:38 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
Q - TO RECLASS CABLE TB EXPS						
1.00	CLINIC	90.00	0	2,776	0	1.00
2.00	OPERATION OF PLANT	7.00	0	26,104	0	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	2,713	0	3.00
	TOTALS		0	31,593		
S - PLANT OPERATIONS SALARIES						
1.00	OPERATION OF PLANT	7.00	38,397	0	0	1.00
	TOTALS		38,397	0		
500.00	Grand Total: Decreases		4,077,817	14,258,086		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/31/2022 9:38 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	963,454	0	0	0	0	1.00	
2.00	Land Improvements	2,211,646	196,998	0	196,998	0	2.00	
3.00	Buildings and Fixtures	111,335,683	96,999	0	96,999	68,840	3.00	
4.00	Building Improvements	24,000	0	0	0	0	4.00	
5.00	Fixed Equipment	5,463,846	48,669	0	48,669	83,631	5.00	
6.00	Movable Equipment	48,397,526	2,203,511	0	2,203,511	2,974,303	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	168,396,155	2,546,177	0	2,546,177	3,126,774	8.00	
9.00	Reconciling Items	199,580	36,358	0	36,358	105,200	9.00	
10.00	Total (line 8 minus line 9)	168,196,575	2,509,819	0	2,509,819	3,021,574	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	963,454	0					1.00
2.00	Land Improvements	2,408,644	0					2.00
3.00	Buildings and Fixtures	111,363,842	0					3.00
4.00	Building Improvements	24,000	0					4.00
5.00	Fixed Equipment	5,428,884	0					5.00
6.00	Movable Equipment	47,626,734	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	167,815,558	0					8.00
9.00	Reconciling Items	130,738	0					9.00
10.00	Total (line 8 minus line 9)	167,684,820	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,129,544	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,947,745	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,077,289	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	3,129,544				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	167,914	4,115,659				2.00
3.00	Total (sum of lines 1-2)	167,914	7,245,203				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	120,058,085	0	120,058,085	0.715975	126,408	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47,626,734	0	47,626,734	0.284025	50,145	2.00
3.00	Total (sum of lines 1-2)	167,684,819	0	167,684,819	1.000000	176,553	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	118,870	0	245,278	3,129,544	221,638	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47,156	0	97,301	3,947,745	0	2.00
3.00	Total (sum of lines 1-2)	166,026	0	342,579	7,077,289	221,638	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	126,408	118,870	0	3,596,460	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	50,145	47,156	167,914	4,212,960	2.00
3.00	Total (sum of lines 1-2)	0	176,553	166,026	167,914	7,809,420	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-784,063	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-307,023	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	37	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-91	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-31,593	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,228,756			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	301,086			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	B	-64,316	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-220	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0289

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

Worksheet A-8

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER MISC INCOME	B	-300,483	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE CR CARD SHARING REV	B	-43,113	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REVENUE ARI	B	-60,628	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MANAGEMENT FEES	B	-224,420	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OB LACTATION REVENUE	B	-19,789	DELIVERY ROOM & LABOR ROOM	52.00	0	33.04
33.05	AH OTHER REVENUE HEALTH MGM	B	-8,598	CARDIOPULMONARY	69.01	0	33.05
33.06	SALES TAX REVERSAL	A	-3	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITMENT	A	-160,008	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING PORTION OF DUES	A	-38,645	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PUBLICITY SALARIES	A	-83,453	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PUBLICITY EXPENSES	A	-67,741	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PUBLICITY BENEFITS	A	-17,784	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	DONATION EXPENSE	A	-66,422	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PROVIDER TAX OFFSET	A	-7,872,645	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ADVERTISING EXPENSE	A	-135,920	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ADVERTISING EXPENSE	A	-5,100	CLINIC	90.00	0	33.15
33.16	AUDIOLOGY REVENUE	B	-35,466	AUDIOLOGY	68.01	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,255,157				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: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2022 9:38 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	ANDERSON HO	902,129	2,147,112	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ANDERSON HO	13,013,502	12,114,619	2.00
3.00	7.00	OPERATION OF PLANT	ANDERSON HO	137,225	0	3.00
3.01	13.00	NURSING ADMINISTRATION	ANDERSON HO	194,731	0	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	ANDERSON HO	1,404,066	1,186,326	3.02
4.00	54.00	RADIOLOGY-DIAGNOSTIC	ANDERSON HO	429,146	331,656	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,080,799	15,779,713	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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	ANDERSON HEALTH	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: 14-0289

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2022 9:38 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	-1,244,983	0		1.00
2.00	898,883	0		2.00
3.00	137,225	0		3.00
3.01	194,731	0		3.01
3.02	217,740	0		3.02
4.00	97,490	0		4.00
5.00	301,086			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	HEALTH CARE		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: 14-0289

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2022 9:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,071,884	3,071,884	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	12,000	0	12,000	211,500	65	2.00
3.00	53.00	ANESTHESIOLOGY	175,000	0	175,000	239,400	888	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	191,933	0	191,933	271,900	1,050	4.00
5.00	59.00	CARDIAC CATHETERIZATION	25,000	0	25,000	246,400	78	5.00
6.00	91.00	EMERGENCY	8,250	8,250	0	211,500	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,484,067	3,080,134	403,933		2,081	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	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	6,609	330	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	102,205	5,110	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	137,257	6,863	0	0	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	9,240	462	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			255,311	12,765	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	0	0	3,071,884		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	6,609	5,391	5,391		2.00
3.00	53.00	ANESTHESIOLOGY	0	102,205	72,795	72,795		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	137,257	54,676	54,676		4.00
5.00	59.00	CARDIAC CATHETERIZATION	0	9,240	15,760	15,760		5.00
6.00	91.00	EMERGENCY	0	0	0	8,250		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	255,311	148,622	3,228,756		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,596,460	3,596,460			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,212,960		4,212,960		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,326,528	9,903	40,952	12,377,383	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,856,475	314,898	878,868	1,751,224	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,009,913	22,972	132,050	220,830	6.00
7.00	00700	OPERATION OF PLANT	2,271,985	286,649	387,995	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	586,607	3,396	0	14,433	8.00
9.00	00900	HOUSEKEEPING	1,775,624	23,520	19,370	315,130	9.00
10.00	01000	DIETARY	742,730	87,048	38,344	69,047	10.00
11.00	01100	CAFETERIA	1,344,278	0	0	124,970	11.00
13.00	01300	NURSING ADMINISTRATION	896,154	22,028	0	142,346	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,094,206	80,066	40,280	193,895	14.00
15.00	01500	PHARMACY	7,566,227	19,584	126,807	390,550	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,483,855	70,067	2,934	247,443	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	91,049	0	0	20,083	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,458,809	312,970	115,340	2,061,848	30.00
31.00	03100	INTENSIVE CARE UNIT	3,067,905	73,027	61,385	540,634	31.00
41.00	04100	SUBPROVIDER - IRF	769,083	32,740	2,557	103,841	41.00
43.00	04300	NURSERY	1,349,662	8,110	32,539	262,622	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,346,324	249,203	552,242	1,238,720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,965,639	244,585	47,866	386,331	52.00
53.00	05300	ANESTHESIOLOGY	222,126	0	8,018	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,116,604	16,822	285,603	511,292	54.00
56.00	05600	RADIOISOTOPE	227,709	8,245	134,275	32,484	56.00
57.00	05700	CT SCAN	1,209,414	116,059	378,741	114,876	57.00
58.00	05800	MRI	593,997	24,170	38,289	43,963	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,075,839	0	318,524	209,835	59.00
60.00	06000	LABORATORY	5,995,903	72,543	293,950	389,570	60.00
65.00	06500	RESPIRATORY THERAPY	1,735,449	47,690	44,793	280,706	65.00
66.00	06600	PHYSICAL THERAPY	1,533,978	117,884	17,076	299,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	900,995	224,326	2,364	185,115	67.00
68.00	06800	SPEECH PATHOLOGY	780,917	95,134	0	160,848	68.00
68.01	03040	AUDIOLOGY	175,177	0	0	41,389	68.01
69.00	06900	ELECTROCARDIOLOGY	736,222	0	58,714	115,473	69.00
69.01	03160	CARDIOPULMONARY	984,248	38,430	5,181	136,846	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	60,845	0	2,820	12,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,961,081	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,168	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,471,452	85,850	87,268	180,017	90.00
91.00	09100	EMERGENCY	7,915,443	233,206	57,815	1,309,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,391,287	13,775	0	269,466	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,909,327	2,954,900	4,212,960	12,377,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	16,854	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	382,851	0	0	192.00
193.00	19300	NONPAID WORKERS	0	241,855	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	141,909,327	3,596,460	4,212,960	12,377,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,801,465					5.00
6.00	00600	MAINTENANCE & REPAIRS	581,273	2,967,038				6.00
7.00	00700	OPERATION OF PLANT	717,923	261,798	3,926,350			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	147,266	3,102	4,502	759,306		8.00
9.00	00900	HOUSEKEEPING	519,845	21,481	31,177	0	2,706,147	9.00
10.00	01000	DIETARY	228,334	79,502	115,388	0	8,733	10.00
11.00	01100	CAFETERIA	357,971	0	0	0	16,049	11.00
13.00	01300	NURSING ADMINISTRATION	258,389	20,118	29,199	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	343,157	73,124	106,131	11,307	8,261	14.00
15.00	01500	PHARMACY	1,974,272	17,886	25,960	0	30,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	439,603	63,993	92,878	0	11,801	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	27,076	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,398,550	285,837	414,859	280,510	973,797	30.00
31.00	03100	INTENSIVE CARE UNIT	911,940	66,696	96,802	42,213	338,681	31.00
41.00	04100	SUBPROVIDER - IRF	221,281	29,902	43,399	0	113,287	41.00
43.00	04300	NURSERY	402,724	7,407	10,750	0	141,373	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,530,585	227,598	330,333	114,252	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	644,292	223,380	324,211	83,949	207,929	52.00
53.00	05300	ANESTHESIOLOGY	56,073	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,201,233	15,364	22,299	21,038	55,936	54.00
56.00	05600	RADIOISOTOPE	98,118	7,530	10,929	1,870	4,956	56.00
57.00	05700	CT SCAN	443,207	105,997	153,843	38,815	103,139	57.00
58.00	05800	MRI	170,651	22,075	32,039	6,985	18,645	58.00
59.00	05900	CARDIAC CATHETERIZATION	390,850	0	0	6,744	0	59.00
60.00	06000	LABORATORY	1,645,063	66,254	96,160	0	65,376	60.00
65.00	06500	RESPIRATORY THERAPY	513,753	43,556	63,216	0	85,909	65.00
66.00	06600	PHYSICAL THERAPY	479,652	107,664	156,263	4,390	28,794	66.00
67.00	06700	OCCUPATIONAL THERAPY	319,853	204,878	297,358	28,627	19,353	67.00
68.00	06800	SPEECH PATHOLOGY	252,632	86,887	126,106	1,909	12,509	68.00
68.01	03040	AUDIOLOGY	52,765	0	0	556	3,540	68.01
69.00	06900	ELECTROCARDIOLOGY	221,814	0	0	4,026	0	69.00
69.01	03160	CARDIOPULMONARY	283,771	35,098	50,941	0	12,981	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	18,479	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,670,580	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,990	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,393,682	78,407	113,799	0	0	90.00
91.00	09100	EMERGENCY	2,318,522	212,988	309,128	112,115	444,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	407,985	12,581	18,260	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,645,154	2,381,103	3,075,930	759,306	2,706,147	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,106	15,393	22,341	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	93,279	349,655	507,486	0	0	192.00
193.00	19300	NONPAID WORKERS	58,926	220,887	320,593	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,801,465	2,967,038	3,926,350	759,306	2,706,147	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,369,126					10.00
11.00	01100	CAFETERIA	0	1,843,268				11.00
13.00	01300	NURSING ADMINISTRATION	0	253,239	1,621,473			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	81,828	0	2,032,255		14.00
15.00	01500	PHARMACY	0	57,293	0	6,665	10,215,454	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	91,321	0	39	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	19,387	9,658	1	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,184,981	444,905	570,289	76,603	21,667	30.00
31.00	03100	INTENSIVE CARE UNIT	116,275	94,463	99,840	27,320	5,310	31.00
41.00	04100	SUBPROVIDER - IRF	67,870	50,608	31,221	1,641	721	41.00
43.00	04300	NURSERY	0	31,488	60,533	6,551	315	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	55,154	314,232	113,685	1,691	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	46,329	89,059	9,636	463	52.00
53.00	05300	ANESTHESIOLOGY	0	33,092	0	13,111	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,240	0	6,248	0	54.00
56.00	05600	RADIOISOTOPE	0	3,409	0	150	0	56.00
57.00	05700	CT SCAN	0	70,597	0	17,065	0	57.00
58.00	05800	MRI	0	12,702	0	417	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	39,307	0	0	59.00
60.00	06000	LABORATORY	0	88,981	0	281,556	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	47,466	0	8,916	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,925	0	556	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,972	0	465	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,092	0	124	0	68.00
68.01	03040	AUDIOLOGY	0	2,674	0	332	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	45,861	0	1,044	0	69.00
69.01	03160	CARDIOPULMONARY	0	51,945	34,703	660	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	4,043	68	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,404,506	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,184,274	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	8,362	0	90.00
91.00	09100	EMERGENCY	0	159,578	306,820	45,642	1,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	61,768	892	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,369,126	1,824,549	1,621,473	2,032,255	10,215,454	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	0	18,719	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,369,126	1,843,268	1,621,473	2,032,255	10,215,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	2,503,934					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	167,254			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	278,495	0	0	21,879,460	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,605	0	0	5,571,096	0	31.00
41.00	04100	SUBPROVIDER - IRF	10,206	0	0	1,478,357	0	41.00
43.00	04300	NURSERY	17,300	0	0	2,331,374	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	309,571	0	0	14,383,590	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,492	0	0	4,299,161	0	52.00
53.00	05300	ANESTHESIOLOGY	55,241	0	0	387,661	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152,680	0	0	6,443,359	0	54.00
56.00	05600	RADIOISOTOPE	13,547	0	0	543,222	0	56.00
57.00	05700	CT SCAN	281,698	0	0	3,033,451	0	57.00
58.00	05800	MRI	50,710	0	0	1,014,643	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	41,282	0	0	2,082,381	0	59.00
60.00	06000	LABORATORY	365,774	0	0	9,361,130	0	60.00
65.00	06500	RESPIRATORY THERAPY	62,610	0	0	2,934,064	0	65.00
66.00	06600	PHYSICAL THERAPY	43,067	0	0	2,809,986	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,950	0	0	2,223,256	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,005	0	0	1,540,163	0	68.00
68.01	03040	AUDIOLOGY	5,309	0	0	281,742	0	68.01
69.00	06900	ELECTROCARDIOLOGY	70,894	0	0	1,254,048	0	69.00
69.01	03160	CARDIOPULMONARY	13,364	0	0	1,648,168	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	8,055	0	0	106,491	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	90,665	0	0	15,126,832	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,797	0	0	10,374,071	0	73.00
74.00	07400	RENAL DIALYSIS	3,661	0	0	13,819	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	46,134	0	0	12,464,971	0	90.00
91.00	09100	EMERGENCY	293,369	0	167,254	13,887,419	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,453	0	0	2,182,467	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,503,934	0	167,254	139,656,382	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	58,694	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	1,351,990	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	842,261	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,503,934	0	167,254	141,909,327	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,903	40,952	50,855	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	445,601	314,898	878,868	1,639,367	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	22,972	132,050	155,022	6.00
7.00	00700	OPERATION OF PLANT	0	286,649	387,995	674,644	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,396	0	3,396	8.00
9.00	00900	HOUSEKEEPING	0	23,520	19,370	42,890	9.00
10.00	01000	DIETARY	2,092	87,048	38,344	127,484	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	22,028	0	22,028	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,592	80,066	40,280	182,938	14.00
15.00	01500	PHARMACY	265,836	19,584	126,807	412,227	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	70,067	2,934	73,001	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	83	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,080	312,970	115,340	429,390	30.00
31.00	03100	INTENSIVE CARE UNIT	0	73,027	61,385	134,412	31.00
41.00	04100	SUBPROVIDER - IRF	0	32,740	2,557	35,297	41.00
43.00	04300	NURSERY	0	8,110	32,539	40,649	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	168,859	249,203	552,242	970,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	244,585	47,866	292,451	52.00
53.00	05300	ANESTHESIOLOGY	0	0	8,018	8,018	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	868,053	16,822	285,603	1,170,478	54.00
56.00	05600	RADIOISOTOPE	0	8,245	134,275	142,520	56.00
57.00	05700	CT SCAN	106,501	116,059	378,741	601,301	57.00
58.00	05800	MRI	230,554	24,170	38,289	293,013	58.00
59.00	05900	CARDIAC CATHETERIZATION	154,105	0	318,524	472,629	59.00
60.00	06000	LABORATORY	8,724	72,543	293,950	375,217	60.00
65.00	06500	RESPIRATORY THERAPY	111,059	47,690	44,793	203,542	65.00
66.00	06600	PHYSICAL THERAPY	60,974	117,884	17,076	195,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	224,326	2,364	226,690	67.00
68.00	06800	SPEECH PATHOLOGY	0	95,134	0	95,134	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	63,023	0	58,714	121,737	69.00
69.01	03160	CARDIOPULMONARY	0	38,430	5,181	43,611	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,820	2,820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	762,559	85,850	87,268	935,677	90.00
91.00	09100	EMERGENCY	0	233,206	57,815	291,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	13,775	0	13,775	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,311,612	2,954,900	4,212,960	10,479,472	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	16,854	0	16,854	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	382,851	0	382,851	192.00
193.00	19300	NONPAID WORKERS	0	241,855	0	241,855	193.00
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)	3,311,612	3,596,460	4,212,960	11,121,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,646,562					5.00
6.00	00600	MAINTENANCE & REPAIRS	34,427	190,356				6.00
7.00	00700	OPERATION OF PLANT	42,520	16,796	733,960			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,722	199	842	13,218		8.00
9.00	00900	HOUSEKEEPING	30,788	1,378	5,828	0	82,179	9.00
10.00	01000	DIETARY	13,523	5,101	21,570	0	265	10.00
11.00	01100	CAFETERIA	21,201	0	0	0	487	11.00
13.00	01300	NURSING ADMINISTRATION	15,303	1,291	5,458	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,324	4,691	19,839	197	251	14.00
15.00	01500	PHARMACY	116,929	1,148	4,853	0	917	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,036	4,106	17,362	0	358	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	1,604	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	201,269	18,338	77,550	4,883	29,573	30.00
31.00	03100	INTENSIVE CARE UNIT	54,011	4,279	18,095	735	10,285	31.00
41.00	04100	SUBPROVIDER - IRF	13,106	1,918	8,113	0	3,440	41.00
43.00	04300	NURSERY	23,852	475	2,009	0	4,293	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	149,877	14,602	61,750	1,989	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,159	14,331	60,605	1,461	6,314	52.00
53.00	05300	ANESTHESIOLOGY	3,321	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,145	986	4,168	366	1,699	54.00
56.00	05600	RADIOISOTOPE	5,811	483	2,043	33	151	56.00
57.00	05700	CT SCAN	26,249	6,800	28,758	676	3,132	57.00
58.00	05800	MRI	10,107	1,416	5,989	122	566	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,149	0	0	117	0	59.00
60.00	06000	LABORATORY	97,431	4,251	17,975	0	1,985	60.00
65.00	06500	RESPIRATORY THERAPY	30,428	2,794	11,817	0	2,609	65.00
66.00	06600	PHYSICAL THERAPY	28,408	6,907	29,210	76	874	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,944	13,144	55,586	498	588	67.00
68.00	06800	SPEECH PATHOLOGY	14,962	5,574	23,573	33	380	68.00
68.01	03040	AUDIOLOGY	3,125	0	0	10	108	68.01
69.00	06900	ELECTROCARDIOLOGY	13,137	0	0	70	0	69.00
69.01	03160	CARDIOPULMONARY	16,807	2,252	9,523	0	394	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,094	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,168	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	118	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	141,769	5,030	21,273	0	0	90.00
91.00	09100	EMERGENCY	137,317	13,665	57,786	1,952	13,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	24,163	807	3,413	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,637,304	152,762	574,988	13,218	82,179	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	243	988	4,176	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,525	22,435	94,867	0	0	192.00
193.00	19300	NONPAID WORKERS	3,490	14,171	59,929	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,646,562	190,356	733,960	13,218	82,179	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	168,227					10.00
11.00	01100	CAFETERIA	0	22,201				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,050	47,715			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	986	0	230,023		14.00
15.00	01500	PHARMACY	0	690	0	754	539,123	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,100	0	4	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	234	284	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	145,601	5,357	16,781	8,670	1,143	30.00
31.00	03100	INTENSIVE CARE UNIT	14,287	1,138	2,938	3,092	280	31.00
41.00	04100	SUBPROVIDER - IRF	8,339	610	919	186	38	41.00
43.00	04300	NURSERY	0	379	1,781	741	17	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	664	9,247	12,868	89	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	558	2,621	1,091	24	52.00
53.00	05300	ANESTHESIOLOGY	0	399	0	1,484	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	461	0	707	0	54.00
56.00	05600	RADIOISOTOPE	0	41	0	17	0	56.00
57.00	05700	CT SCAN	0	850	0	1,932	0	57.00
58.00	05800	MRI	0	153	0	47	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,157	0	0	59.00
60.00	06000	LABORATORY	0	1,072	0	31,868	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	572	0	1,009	0	65.00
66.00	06600	PHYSICAL THERAPY	0	252	0	63	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168	0	53	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	110	0	14	0	68.00
68.01	03040	AUDIOLOGY	0	32	0	38	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	552	0	118	0	69.00
69.01	03160	CARDIOPULMONARY	0	626	1,021	75	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	119	8	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	158,971	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	537,479	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	946	0	90.00
91.00	09100	EMERGENCY	0	1,922	9,029	5,166	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	1,818	101	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,227	21,976	47,715	230,023	539,123	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	0	225	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	168,227	22,201	47,715	230,023	539,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
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	122,984					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	2,205			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,679	0		960,706	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,405	0		247,178	0	31.00
41.00	04100	SUBPROVIDER - IRF	501	0		72,894	0	41.00
43.00	04300	NURSERY	850	0		76,125	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,205	0		1,241,684	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,252	0		420,454	0	52.00
53.00	05300	ANESTHESIOLOGY	2,713	0		15,935	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,499	0		1,259,610	0	54.00
56.00	05600	RADIOISOTOPE	665	0		151,897	0	56.00
57.00	05700	CT SCAN	13,836	0		684,006	0	57.00
58.00	05800	MRI	2,491	0		314,085	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,028	0		499,942	0	59.00
60.00	06000	LABORATORY	17,965	0		549,365	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,075	0		256,999	0	65.00
66.00	06600	PHYSICAL THERAPY	2,115	0		265,070	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,275	0		317,707	0	67.00
68.00	06800	SPEECH PATHOLOGY	688	0		141,129	0	68.00
68.01	03040	AUDIOLOGY	261	0		3,744	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,482	0		139,570	0	69.00
69.01	03160	CARDIOPULMONARY	656	0		75,527	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	396	0		4,487	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,453	0		321,592	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,322	0		546,801	0	73.00
74.00	07400	RENAL DIALYSIS	180	0		298	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,266	0		1,107,701	0	90.00
91.00	09100	EMERGENCY	14,409	0		551,211	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	317	0		45,501	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,984	0	0	10,271,218	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		22,261	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		505,903	0	192.00
193.00	19300	NONPAID WORKERS	0	0		319,445	0	193.00
200.00		Cross Foot Adjustments			2,205	2,205	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	122,984	0	2,205	11,121,032	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0289

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
68.01	03040	AUDIOLOGY	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	453,232				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,578,702			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,248	25,066	59,338,503		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,684	537,945	8,395,572	-27,801,465	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,895	80,826	1,058,686	0	6.00
7.00	00700	OPERATION OF PLANT	36,124	237,487	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	0	69,193	0	8.00
9.00	00900	HOUSEKEEPING	2,964	11,856	1,510,772	0	9.00
10.00	01000	DIETARY	10,970	23,470	331,021	0	10.00
11.00	01100	CAFETERIA	0	0	599,121	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	0	682,422	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,090	24,655	929,555	0	14.00
15.00	01500	PHARMACY	2,468	77,617	1,872,342	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	1,796	1,186,272	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	96,280	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,441	70,598	9,884,625	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	37,573	2,591,864	0	31.00
41.00	04100	SUBPROVIDER - IRF	4,126	1,565	497,826	0	41.00
43.00	04300	NURSERY	1,022	19,917	1,259,039	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	31,405	338,021	5,938,569	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	29,298	1,852,114	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,908	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,120	174,814	2,451,195	0	54.00
56.00	05600	RADIOISOTOPE	1,039	82,188	155,730	0	56.00
57.00	05700	CT SCAN	14,626	231,823	550,728	0	57.00
58.00	05800	MRI	3,046	23,436	210,764	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	194,965	1,005,972	0	59.00
60.00	06000	LABORATORY	9,142	179,923	1,867,644	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	27,417	1,345,736	0	65.00
66.00	06600	PHYSICAL THERAPY	14,856	10,452	1,436,975	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,270	1,447	887,464	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,989	0	771,122	0	68.00
68.01	03040	AUDIOLOGY	0	0	198,426	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	35,938	553,589	0	69.00
69.01	03160	CARDIOPULMONARY	4,843	3,171	656,058	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,726	58,396	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,819	53,416	863,021	0	90.00
91.00	09100	EMERGENCY	29,389	35,388	6,278,559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,736	0	1,291,851	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,382	2,578,702	59,338,503	-27,801,465	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,124	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	48,247	0	0	0	192.00
193.00	19300	NONPAID WORKERS	30,479	0	0	0	193.00
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)	3,596,460	4,212,960	12,377,383	27,801,465	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.935141	1.633752	0.208589	0.243642	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			50,855	1,646,562	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000857	0.014430	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	409,405					6.00
7.00	00700	OPERATION OF PLANT	36,124	373,281				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	428	1,210,948			8.00
9.00	00900	HOUSEKEEPING	2,964	2,964	0	11,466		9.00
10.00	01000	DIETARY	10,970	10,970	0	37	96,083	10.00
11.00	01100	CAFETERIA	0	0	0	68	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	2,776	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,090	10,090	18,032	35	0	14.00
15.00	01500	PHARMACY	2,468	2,468	0	128	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	8,830	0	50	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,441	39,441	447,360	4,126	83,160	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	9,203	67,321	1,435	8,160	31.00
41.00	04100	SUBPROVIDER - IRF	4,126	4,126	0	480	4,763	41.00
43.00	04300	NURSERY	1,022	1,022	0	599	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,405	31,405	182,211	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	30,823	133,882	881	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,120	2,120	33,551	237	0	54.00
56.00	05600	RADIOISOTOPE	1,039	1,039	2,982	21	0	56.00
57.00	05700	CT SCAN	14,626	14,626	61,903	437	0	57.00
58.00	05800	MRI	3,046	3,046	11,139	79	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	10,756	0	0	59.00
60.00	06000	LABORATORY	9,142	9,142	0	277	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	6,010	0	364	0	65.00
66.00	06600	PHYSICAL THERAPY	14,856	14,856	7,002	122	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,270	28,270	45,654	82	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,989	11,989	3,045	53	0	68.00
68.01	03040	AUDIOLOGY	0	0	887	15	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	6,421	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,843	4,843	0	55	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,819	10,819	0	0	0	90.00
91.00	09100	EMERGENCY	29,389	29,389	178,802	1,885	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,736	1,736	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	328,555	292,431	1,210,948	11,466	96,083	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,124	2,124	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	48,247	48,247	0	0	0	192.00
193.00	19300	NONPAID WORKERS	30,479	30,479	0	0	0	193.00
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)	2,967,038	3,926,350	759,306	2,706,147	1,369,126	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.247195	10.518483	0.627034	236.014914	14.249409	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	190,356	733,960	13,218	82,179	168,227	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.464958	1.966240	0.010915	7.167190	1.750851	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: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	27,572				11.00
13.00	01300	NURSING ADMINISTRATION	3,788	14,438			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,224	0	15,860,216		14.00
15.00	01500	PHARMACY	857	0	52,013	3,599,712	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,366	0	302	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	290	86	6	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,655	5,078	597,834	7,635	30.00
31.00	03100	INTENSIVE CARE UNIT	1,413	889	213,212	1,871	31.00
41.00	04100	SUBPROVIDER - IRF	757	278	12,804	254	41.00
43.00	04300	NURSERY	471	539	51,123	111	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	825	2,798	887,232	596	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	693	793	75,202	163	52.00
53.00	05300	ANESTHESIOLOGY	495	0	102,320	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572	0	48,760	0	54.00
56.00	05600	RADIOISOTOPE	51	0	1,174	0	56.00
57.00	05700	CT SCAN	1,056	0	133,181	0	57.00
58.00	05800	MRI	190	0	3,255	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	350	0	0	59.00
60.00	06000	LABORATORY	1,331	0	2,197,341	0	60.00
65.00	06500	RESPIRATORY THERAPY	710	0	69,584	0	65.00
66.00	06600	PHYSICAL THERAPY	313	0	4,342	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209	0	3,632	0	67.00
68.00	06800	SPEECH PATHOLOGY	136	0	968	0	68.00
68.01	03040	AUDIOLOGY	40	0	2,592	0	68.01
69.00	06900	ELECTROCARDIOLOGY	686	0	8,149	0	69.00
69.01	03160	CARDIOPULMONARY	777	309	5,152	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	36	534	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,961,081	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,588,725	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	65,257	0	90.00
91.00	09100	EMERGENCY	2,387	2,732	356,205	357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	550	6,961	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,292	14,438	15,860,216	3,599,712	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	280	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
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)	1,843,268	1,621,473	2,032,255	10,215,454	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.852894	112.305929	0.128135	2.837853	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,201	47,715	230,023	539,123	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.805201	3.304821	0.014503	0.149768	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: 14-0289

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

Worksheet B-1

Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)	
		17.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
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	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
68.01	03040	AUDIOLOGY	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03160	CARDIOPULMONARY	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
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)	167,254	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,672.540000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,205	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	22.050000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:38 am

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,879,460	21,879,460	5,391	21,884,851
31.00	03100	INTENSIVE CARE UNIT	5,571,096	5,571,096	0	5,571,096
41.00	04100	SUBPROVIDER - IRF	1,478,357	1,478,357	0	1,478,357
43.00	04300	NURSERY	2,331,374	2,331,374	0	2,331,374
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,383,590	14,383,590	0	14,383,590
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,299,161	4,299,161	0	4,299,161
53.00	05300	ANESTHESIOLOGY	387,661	387,661	72,795	460,456
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,443,359	6,443,359	54,676	6,498,035
56.00	05600	RADIOISOTOPE	543,222	543,222	0	543,222
57.00	05700	CT SCAN	3,033,451	3,033,451	0	3,033,451
58.00	05800	MRI	1,014,643	1,014,643	0	1,014,643
59.00	05900	CARDIAC CATHETERIZATION	2,082,381	2,082,381	15,760	2,098,141
60.00	06000	LABORATORY	9,361,130	9,361,130	0	9,361,130
65.00	06500	RESPIRATORY THERAPY	2,934,064	2,934,064	0	2,934,064
66.00	06600	PHYSICAL THERAPY	2,809,986	2,809,986	0	2,809,986
67.00	06700	OCCUPATIONAL THERAPY	2,223,256	2,223,256	0	2,223,256
68.00	06800	SPEECH PATHOLOGY	1,540,163	1,540,163	0	1,540,163
68.01	03040	AUDIOLOGY	281,742	281,742	0	281,742
69.00	06900	ELECTROCARDIOLOGY	1,254,048	1,254,048	0	1,254,048
69.01	03160	CARDIOPULMONARY	1,648,168	1,648,168	0	1,648,168
70.00	07000	ELECTROENCEPHALOGRAPHY	106,491	106,491	0	106,491
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,126,832	15,126,832	0	15,126,832
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	10,374,071	10,374,071	0	10,374,071
74.00	07400	RENAL DIALYSIS	13,819	13,819	0	13,819
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,464,971	12,464,971	0	12,464,971
91.00	09100	EMERGENCY	13,887,419	13,887,419	0	13,887,419
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,511,279	3,511,279	0	3,511,279
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,182,467	2,182,467	0	2,182,467
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	143,167,661	143,167,661	148,622	143,316,283
201.00		Less Observation Beds	3,511,279	3,511,279	0	3,511,279
202.00		Total (see instructions)	139,656,382	139,656,382	148,622	139,805,004

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN:14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 5/31/2022 9:38 am	
				Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
9.00			10.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	50,467,183		50,467,183			30.00	
31.00	03100	INTENSIVE CARE UNIT	7,993,739		7,993,739			31.00	
41.00	04100	SUBPROVIDER - IRF	2,850,772		2,850,772			41.00	
43.00	04300	NURSERY	4,838,276		4,838,276			43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	16,270,980	70,198,026	86,469,006	0.166344	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,086,669	30,694	7,117,363	0.604038	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,674,770	12,757,239	15,432,009	0.025121	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,519,326	33,129,905	42,649,231	0.151078	0.000000	54.00	
56.00	05600	RADIOISOTOPE	531,766	3,258,544	3,790,310	0.143319	0.000000	56.00	
57.00	05700	CT SCAN	18,151,146	60,539,125	78,690,271	0.038549	0.000000	57.00	
58.00	05800	MRI	2,570,549	11,589,344	14,159,893	0.071656	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	6,428,508	5,098,516	11,527,024	0.180652	0.000000	59.00	
60.00	06000	LABORATORY	42,129,068	60,049,046	102,178,114	0.091616	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	12,196,084	5,289,527	17,485,611	0.167799	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	4,137,177	7,890,503	12,027,680	0.233627	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,585,736	3,666,008	7,251,744	0.306582	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	839,948	3,074,393	3,914,341	0.393467	0.000000	68.00	
68.01	03040	AUDIOLOGY	0	1,478,874	1,478,874	0.190511	0.000000	68.01	
69.00	06900	ELECTROCARDIOLOGY	7,054,761	12,747,645	19,802,406	0.063328	0.000000	69.00	
69.01	03160	CARDIOPULMONARY	711,918	3,014,986	3,726,904	0.442235	0.000000	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	151,236	2,103,153	2,254,389	0.047237	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,226,124	17,101,677	25,327,801	0.597242	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	18,903,862	34,111,514	53,015,376	0.195680	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	931,847	84,703	1,016,550	0.013594	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	12,634	12,872,995	12,885,629	0.967354	0.000000	90.00	
91.00	09100	EMERGENCY	15,616,166	66,336,826	81,952,992	0.169456	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,126,588	16,199,666	27,326,254	0.128495	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	1,802,518	1,802,518			101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	255,006,833	444,425,427	699,432,260			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	255,006,833	444,425,427	699,432,260			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.166344			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.604038			52.00
53.00	05300	ANESTHESIOLOGY	0.029838			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152360			54.00
56.00	05600	RADIOISOTOPE	0.143319			56.00
57.00	05700	CT SCAN	0.038549			57.00
58.00	05800	MRI	0.071656			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182019			59.00
60.00	06000	LABORATORY	0.091616			60.00
65.00	06500	RESPIRATORY THERAPY	0.167799			65.00
66.00	06600	PHYSICAL THERAPY	0.233627			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306582			67.00
68.00	06800	SPEECH PATHOLOGY	0.393467			68.00
68.01	03040	AUDIOLOGY	0.190511			68.01
69.00	06900	ELECTROCARDIOLOGY	0.063328			69.00
69.01	03160	CARDIOPULMONARY	0.442235			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.047237			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.597242			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195680			73.00
74.00	07400	RENAL DIALYSIS	0.013594			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.967354			90.00
91.00	09100	EMERGENCY	0.169456			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.128495			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/31/2022 9:38 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	960,706	0	960,706	25,280	38.00	30.00
31.00	INTENSIVE CARE UNIT	247,178		247,178	2,529	97.74	31.00
41.00	SUBPROVIDER - IRF	72,894	0	72,894	1,476	49.39	41.00
43.00	NURSERY	76,125		76,125	2,898	26.27	43.00
200.00	Total (lines 30 through 199)	1,356,903		1,356,903	32,183		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,276	276,488				30.00
31.00	INTENSIVE CARE UNIT	831	81,222				31.00
41.00	SUBPROVIDER - IRF	838	41,389				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	8,945	399,099				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/31/2022 9:38 am			
				Title XVIII		Hospital			
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)	PPS
				1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,241,684	86,469,006	0.014360	4,041,006	58,029	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	420,454	7,117,363	0.059074	19,801	1,170	52.00	
53.00	05300	ANESTHESIOLOGY	15,935	15,432,009	0.001033	701,980	725	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,259,610	42,649,231	0.029534	3,532,082	104,317	54.00	
56.00	05600	RADIOISOTOPE	151,897	3,790,310	0.040075	241,873	9,693	56.00	
57.00	05700	CT SCAN	684,006	78,690,271	0.008692	6,613,913	57,488	57.00	
58.00	05800	MRI	314,085	14,159,893	0.022181	868,276	19,259	58.00	
59.00	05900	CARDIAC CATHETERIZATION	499,942	11,527,024	0.043371	1,596,490	69,241	59.00	
60.00	06000	LABORATORY	549,365	102,178,114	0.005377	13,644,616	73,367	60.00	
65.00	06500	RESPIRATORY THERAPY	256,999	17,485,611	0.014698	4,077,947	59,938	65.00	
66.00	06600	PHYSICAL THERAPY	265,070	12,027,680	0.022038	1,329,747	29,305	66.00	
67.00	06700	OCCUPATIONAL THERAPY	317,707	7,251,744	0.043811	1,129,604	49,489	67.00	
68.00	06800	SPEECH PATHOLOGY	141,129	3,914,341	0.036054	242,956	8,760	68.00	
68.01	03040	AUDIOLOGY	3,744	1,478,874	0.002532	0	0	68.01	
69.00	06900	ELECTROCARDIOLOGY	139,570	19,802,406	0.007048	2,680,107	18,889	69.00	
69.01	03160	CARDIOPULMONARY	75,527	3,726,904	0.020265	272,878	5,530	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	4,487	2,254,389	0.001990	65,871	131	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,592	25,327,801	0.012697	2,659,299	33,765	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	546,801	53,015,376	0.010314	5,522,123	56,955	73.00	
74.00	07400	RENAL DIALYSIS	298	1,016,550	0.000293	535,754	157	74.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,107,701	12,885,629	0.085964	2,121	182	90.00	
91.00	09100	EMERGENCY	551,211	81,952,992	0.006726	5,548,782	37,321	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	154,138	27,326,254	0.005641	3,249,263	18,329	92.00	
200.00		Total (lines 50 through 199)	9,022,952	631,479,772		58,576,489	712,040	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/31/2022 9:38 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
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	25,280	0.00	7,276	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	2,529	0.00	831	31.00			
41.00	04100	SUBPROVIDER - IRF	0	0	1,476	0.00	838	41.00			
43.00	04300	NURSERY	0	0	2,898	0.00	0	43.00			
200.00		Total (lines 30 through 199)	0	0	32,183		8,945	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	167,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	167,254	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			Title XVIII		Hospital		PPS
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	86,469,006	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,117,363	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	15,432,009	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,649,231	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	3,790,310	0.000000
57.00	05700	CT SCAN	0	0	0	78,690,271	0.000000
58.00	05800	MRI	0	0	0	14,159,893	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,527,024	0.000000
60.00	06000	LABORATORY	0	0	0	102,178,114	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,485,611	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	12,027,680	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,251,744	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,914,341	0.000000
68.01	03040	AUDIOLOGY	0	0	0	1,478,874	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,802,406	0.000000
69.01	03160	CARDIOPULMONARY	0	0	0	3,726,904	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,254,389	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,327,801	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,015,376	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	1,016,550	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	12,885,629	0.000000
91.00	09100	EMERGENCY	0	167,254	167,254	81,952,992	0.002041
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	27,326,254	0.000000
200.00		Total (lines 50 through 199)	0	167,254	167,254	631,479,772	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:38 am

				Title XVIII		Hospital	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	4,041,006	0	13,079,144	0
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	19,801	0	0	0
53.00	05300	ANESTHESIOLOGY		0.000000	701,980	0	2,321,830	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	3,532,082	0	4,914,989	0
56.00	05600	RADIOISOTOPE		0.000000	241,873	0	839,518	0
57.00	05700	CT SCAN		0.000000	6,613,913	0	13,348,878	0
58.00	05800	MRI		0.000000	868,276	0	2,900,957	0
59.00	05900	CARDIAC CATHETERIZATION		0.000000	1,596,490	0	1,482,170	0
60.00	06000	LABORATORY		0.000000	13,644,616	0	6,899,584	0
65.00	06500	RESPIRATORY THERAPY		0.000000	4,077,947	0	1,112,807	0
66.00	06600	PHYSICAL THERAPY		0.000000	1,329,747	0	95,690	0
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,129,604	0	43,798	0
68.00	06800	SPEECH PATHOLOGY		0.000000	242,956	0	10,025	0
68.01	03040	AUDIOLOGY		0.000000	0	0	91,339	0
69.00	06900	ELECTROCARDIOLOGY		0.000000	2,680,107	0	3,045,147	0
69.01	03160	CARDIOPULMONARY		0.000000	272,878	0	1,009,712	0
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	65,871	0	297,906	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	2,659,299	0	4,067,724	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	5,522,123	0	10,615,193	0
74.00	07400	RENAL DIALYSIS		0.000000	535,754	0	0	0
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC		0.000000	2,121	0	5,255,171	0
91.00	09100	EMERGENCY		0.002041	5,548,782	11,325	8,627,047	17,608
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	3,249,263	0	2,851,945	0
200.00		Total (lines 50 through 199)			58,576,489	11,325	82,910,574	17,608

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/31/2022 9:38 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.166344	13,079,144	0	0	2,175,637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.604038	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025121	2,321,830	0	0	58,327	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151078	4,914,989	0	0	742,547	54.00
56.00	05600	RADIOISOTOPE	0.143319	839,518	0	0	120,319	56.00
57.00	05700	CT SCAN	0.038549	13,348,878	0	0	514,586	57.00
58.00	05800	MRI	0.071656	2,900,957	0	0	207,871	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.180652	1,482,170	0	0	267,757	59.00
60.00	06000	LABORATORY	0.091616	6,899,584	630	0	632,112	60.00
65.00	06500	RESPIRATORY THERAPY	0.167799	1,112,807	0	0	186,728	65.00
66.00	06600	PHYSICAL THERAPY	0.233627	95,690	0	0	22,356	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306582	43,798	0	0	13,428	67.00
68.00	06800	SPEECH PATHOLOGY	0.393467	10,025	0	0	3,945	68.00
68.01	03040	AUDIOLOGY	0.190511	91,339	0	0	17,401	68.01
69.00	06900	ELECTROCARDIOLOGY	0.063328	3,045,147	0	0	192,843	69.00
69.01	03160	CARDIOPULMONARY	0.442235	1,009,712	0	0	446,530	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.047237	297,906	0	0	14,072	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.597242	4,067,724	0	0	2,429,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195680	10,615,193	0	6,804	2,077,181	73.00
74.00	07400	RENAL DIALYSIS	0.013594	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.967354	5,255,171	0	117	5,083,611	90.00
91.00	09100	EMERGENCY	0.169456	8,627,047	0	20	1,461,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.128495	2,851,945	0	0	366,461	92.00
200.00		Subtotal (see instructions)		82,910,574	630	6,941	17,035,033	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		82,910,574	630	6,941	17,035,033	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0289		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/31/2022 9:38 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	58	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
68.01	03040	AUDIOLOGY	0	0					68.01
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.01	03160	CARDIOPULMONARY	0	0					69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,331					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	113					90.00
91.00	09100	EMERGENCY	0	3					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	58	1,447					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	58	1,447					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/31/2022 9:38 am		
				Component CCN:14-T289				
				Title XVIII	Subprovider - IRF	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,241,684	86,469,006	0.014360	15,923	229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	420,454	7,117,363	0.059074	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,935	15,432,009	0.001033	4,322	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,259,610	42,649,231	0.029534	57,144	1,688	54.00
56.00	05600	RADIOISOTOPE	151,897	3,790,310	0.040075	1,990	80	56.00
57.00	05700	CT SCAN	684,006	78,690,271	0.008692	38,426	334	57.00
58.00	05800	MRI	314,085	14,159,893	0.022181	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	499,942	11,527,024	0.043371	266	12	59.00
60.00	06000	LABORATORY	549,365	102,178,114	0.005377	207,945	1,118	60.00
65.00	06500	RESPIRATORY THERAPY	256,999	17,485,611	0.014698	8,668	127	65.00
66.00	06600	PHYSICAL THERAPY	265,070	12,027,680	0.022038	620,191	13,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,707	7,251,744	0.043811	604,165	26,469	67.00
68.00	06800	SPEECH PATHOLOGY	141,129	3,914,341	0.036054	161,923	5,838	68.00
68.01	03040	AUDIOLOGY	3,744	1,478,874	0.002532	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	139,570	19,802,406	0.007048	2,920	21	69.00
69.01	03160	CARDIOPULMONARY	75,527	3,726,904	0.020265	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	4,487	2,254,389	0.001990	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,592	25,327,801	0.012697	21,054	267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	546,801	53,015,376	0.010314	148,161	1,528	73.00
74.00	07400	RENAL DIALYSIS	298	1,016,550	0.000293	22,390	7	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,107,701	12,885,629	0.085964	0	0	90.00
91.00	09100	EMERGENCY	551,211	81,952,992	0.006726	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	27,326,254	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,868,814	631,479,772		1,915,488	51,390	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0289

Component CCN: 14-T289

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:38 am

				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	167,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	167,254	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/31/2022 9:38 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	86,469,006	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,117,363	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,432,009	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,649,231	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,790,310	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	78,690,271	0.000000	57.00
58.00	05800	MRI	0	0	0	14,159,893	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,527,024	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	102,178,114	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,485,611	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,027,680	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,251,744	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,914,341	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	1,478,874	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,802,406	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	3,726,904	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,254,389	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,327,801	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,015,376	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,016,550	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	12,885,629	0.000000	90.00
91.00	09100	EMERGENCY	0	167,254	167,254	81,952,992	0.002041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	27,326,254	0.000000	92.00
200.00		Total (lines 50 through 199)	0	167,254	167,254	631,479,772		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0289

Component CCN:14-T289

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	15,923	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,322	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	57,144	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	1,990	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	38,426	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	266	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	207,945	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	8,668	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	620,191	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	604,165	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	161,923	0	0	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,920	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	21,054	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	148,161	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	22,390	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.002041	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,915,488	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:38 am

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,280	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	21,224	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7,276	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)	21,884,851	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)	21,884,851	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)	21,884,851	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)	865.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,298,833	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	6,298,833	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:38 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,571,096	2,529	2,202.88	831	1,830,593
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,902,053
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,031,479
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					357,710
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					723,365
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,081,075
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,950,404
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)					4,056
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					865.70
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,511,279

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289

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

Worksheet D-1

Date/Time Prepared:
5/31/2022 9:38 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	960,706	21,884,851	0.043898	3,511,279	154,138
91.00	Nursing Program cost	0	21,884,851	0.000000	3,511,279	0
92.00	Allied health cost	0	21,884,851	0.000000	3,511,279	0
93.00	All other Medical Education	0	21,884,851	0.000000	3,511,279	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Component CCN: 14-T289		Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,476	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,476	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)		1,476	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)		838	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)		1,478,357	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)		1,478,357	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)		1,478,357	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)		1,001.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		839,341	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)		839,341	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 14-T289		Date/Time Prepared: 5/31/2022 9:38 am	
				Title XVIII		Subprovider - IRF	PPS
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					469,688	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,309,029	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					41,389	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51,390	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					92,779	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,216,250	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/31/2022 9:38 am	
		Title XVIII		Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	72,894	1,478,357	0.049307	0	0	90.00
91.00 Nursing Program cost	0	1,478,357	0.000000	0	0	91.00
92.00 Allied health cost	0	1,478,357	0.000000	0	0	92.00
93.00 All other Medical Education	0	1,478,357	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/31/2022 9:38 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		13,412,571		30.00
31.00	03100	INTENSIVE CARE UNIT		2,413,487		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.166344	4,041,006	672,197	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.604038	19,801	11,961	52.00
53.00	05300	ANESTHESIOLOGY	0.029838	701,980	20,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152360	3,532,082	538,148	54.00
56.00	05600	RADIOISOTOPE	0.143319	241,873	34,665	56.00
57.00	05700	CT SCAN	0.038549	6,613,913	254,960	57.00
58.00	05800	MRI	0.071656	868,276	62,217	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.182019	1,596,490	290,592	59.00
60.00	06000	LABORATORY	0.091616	13,644,616	1,250,065	60.00
65.00	06500	RESPIRATORY THERAPY	0.167799	4,077,947	684,275	65.00
66.00	06600	PHYSICAL THERAPY	0.233627	1,329,747	310,665	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.306582	1,129,604	346,316	67.00
68.00	06800	SPEECH PATHOLOGY	0.393467	242,956	95,595	68.00
68.01	03040	AUDIOLOGY	0.190511	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.063328	2,680,107	169,726	69.00
69.01	03160	CARDIOPULMONARY	0.442235	272,878	120,676	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.047237	65,871	3,112	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.597242	2,659,299	1,588,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195680	5,522,123	1,080,569	73.00
74.00	07400	RENAL DIALYSIS	0.013594	535,754	7,283	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.967354	2,121	2,052	90.00
91.00	09100	EMERGENCY	0.169456	5,548,782	940,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.128495	3,249,263	417,514	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,576,489	8,902,053	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)		58,576,489		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/31/2022 9:38 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		1,619,702		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.166344	15,923	2,649	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.604038	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.029838	4,322	129	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.152360	57,144	8,706	54.00
56.00	05600 RADIOISOTOPE	0.143319	1,990	285	56.00
57.00	05700 CT SCAN	0.038549	38,426	1,481	57.00
58.00	05800 MRI	0.071656	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.182019	266	48	59.00
60.00	06000 LABORATORY	0.091616	207,945	19,051	60.00
65.00	06500 RESPIRATORY THERAPY	0.167799	8,668	1,454	65.00
66.00	06600 PHYSICAL THERAPY	0.233627	620,191	144,893	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.306582	604,165	185,226	67.00
68.00	06800 SPEECH PATHOLOGY	0.393467	161,923	63,711	68.00
68.01	03040 AUDIOLOGY	0.190511	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.063328	2,920	185	69.00
69.01	03160 CARDIOPULMONARY	0.442235	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.047237	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.597242	21,054	12,574	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.195680	148,161	28,992	73.00
74.00	07400 RENAL DIALYSIS	0.013594	22,390	304	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.967354	0	0	90.00
91.00	09100 EMERGENCY	0.169456	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.128495	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,915,488	469,688	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,915,488		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,762,560	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)		96,333	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)		103.05	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)		2.77	30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.23	31.00
32.00	Sum of lines 30 and 31		24.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.02	33.00
34.00	Disproportionate share adjustment (see instructions)		332,896	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8,290,014,521	7,192,008,710
35.01	Factor 3 (see instructions)		0.000184088	0.000148169
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,526,092	1,065,633
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,141,433	268,598
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,410,031	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	
41.00	Total ESRD Medicare discharges (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	
43.00	Total Medicare ESRD inpatient days (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)		16,601,820	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)			16,601,820
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,177,808
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0
53.00	Nursing and Allied Health Managed Care payment			20,198
54.00	Special add-on payments for new technologies			184,505
54.01	Islet isolation add-on payment			0
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			11,325
59.00	Total (sum of amounts on lines 49 through 58)			17,995,656
60.00	Primary payer payments			59,544
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			17,936,112
62.00	Deductibles billed to program beneficiaries			1,803,403
63.00	Coinsurance billed to program beneficiaries			52,311
64.00	Allowable bad debts (see instructions)			378,183
65.00	Adjusted reimbursable bad debts (see instructions)			245,819
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			368,999
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			16,326,217
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0
70.87	Demonstration payment adjustment amount before sequestration			0
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0
70.92	Bundled Model 1 discount amount (see instructions)			0
70.93	HVBP payment adjustment amount (see instructions)			67,752
70.94	HRR adjustment amount (see instructions)			-65,512
70.95	Recovery of accelerated depreciation			0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/31/2022 9:38 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,328,457	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		15,938,324	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)		390,133	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		477,823	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	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2022 9:38 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,762,560	0		14,762,560	14,762,560
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	96,333	0		96,333	96,333
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0902	0.0902	0.0902	0.0902	
11.00	Disproportionate share adjustment (see instructions)	34.00	332,896	0	0	332,896	332,896
11.01	Uncompensated care payments	36.00	1,410,031	0	854,515	67,701	922,216
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	16,601,820	0	854,515	15,747,305	16,601,820
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,601,820	0	854,515	15,747,305	16,601,820

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2022 9:38 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,177,808	0	0	1,177,808	1,177,808
17.00	Special add-on payments for new technologies	54.00	184,505	0	0	184,505	184,505
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	854,515	17,109,618	17,964,133
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	1,116,183	0	0	1,116,183	1,116,183
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	6,039	0	0	6,039	6,039
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.00000	0.00000	0.00000	0.00000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0498	0.0498	0.0498	0.0498	
25.00	Disproportionate share adjustment (see instructions)	11.00	55,586	0	0	55,586	55,586
26.00	Total prospective capital payments (see instructions)	12.00	1,177,808	0	0	1,177,808	1,177,808
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2022 9:38 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,762,560		14,762,560	14,762,560	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	96,333		96,333	96,333	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0902	0.0902	0.0902		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	332,896	0	332,896	332,896	11.00
11.01	Uncompensated care payments	36.00	1,410,031	854,515	67,701	922,216	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,601,820	854,515	15,747,305	16,601,820	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,601,820	854,515	15,747,305	16,601,820	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,177,808	0	1,177,808	1,177,808	16.00
17.00	Special add-on payments for new technologies	54.00	184,505	0	184,505	184,505	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			854,515	17,109,618	17,964,133	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/31/2022 9:38 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,116,183	0	1,116,183	1,116,183	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,039	0	6,039	6,039	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0498	0.0498	0.0498		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	55,586	0	55,586	55,586	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,177,808	0	1,177,808	1,177,808	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	67,752	0	67,752	67,752	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-65,512	0	-65,512	-65,512	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,505	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,017,425	2.00
3.00	OPPS payments		13,335,166	3.00
4.00	Outlier payment (see instructions)		53,191	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		17,608	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,505	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		7,571	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)		7,571	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)		7,571	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,066	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,505	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)		13,405,965	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,430,611	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)		10,976,859	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)		10,976,859	30.00
31.00	Primary payer payments		8,233	31.00
32.00	Subtotal (line 30 minus line 31)		10,968,626	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)		133,596	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		86,837	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		129,804	36.00
37.00	Subtotal (see instructions)		11,055,463	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-305	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		11,055,768	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		11,149,157	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-93,389	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/31/2022 9:38 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15,878,141		11,149,157	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	09/09/2021	60,183		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		60,183		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,938,324		11,149,157	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		390,133		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		93,389	6.02
7.00	Total Medicare program liability (see instructions)		16,328,457		11,055,768	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0289 Component CCN: 14-T289		Period: From 01/01/2021 To 12/31/2021		Worksheet E-1 Part I Date/Time Prepared: 5/31/2022 9:38 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					0	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		1,658,998			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,658,998			0	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		9,164			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		1,668,162			0	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: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part III Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		1,607,617	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0305	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		69,449	3.00
4.00	Outlier Payments		0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		4.043836	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		1,677,066	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		0	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		1,677,066	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		1,677,066	19.00
20.00	Deductibles		8,904	20.00
21.00	Subtotal (line 19 minus line 20)		1,668,162	21.00
22.00	Coinsurance		0	22.00
23.00	Subtotal (line 21 minus line 22)		1,668,162	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		1,668,162	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.98	Recovery of accelerated depreciation.		0	31.98
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		1,668,162	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		1,658,998	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		9,164	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/31/2022 9:38 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	8,945	6,317		26.00
27.00	Total Inpatient Days (see instructions)	25,721	25,721		27.00
28.00	Ratio of inpatient days to total inpatient days	0.347770	0.245597		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/31/2022 9:38 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,016,550		33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000		34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0		35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0		36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)		18,340,508		37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0		38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0		39.00
40.00	Primary payer payments (see instructions)		59,544		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		18,280,964		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		17,036,538		42.00
43.00	Primary payer payments (see instructions)		8,233		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		17,028,305		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		35,309,269		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.517738		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.482262		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		0		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		0		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		0		50.00

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

Provider CCN: 14-0289

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

Worksheet G

Date/Time Prepared:
5/31/2022 9:38 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,118,079	0	0	0	1.00
2.00	Temporary investments	128,348,315	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	119,504,329	0	0	0	4.00
5.00	Other receivable	238,428	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-94,339,280	0	0	0	6.00
7.00	Inventory	3,491,076	0	0	0	7.00
8.00	Prepaid expenses	1,786,872	0	0	0	8.00
9.00	Other current assets	7,500	0	0	0	9.00
10.00	Due from other funds	563,928	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	165,719,247	0	0	0	11.00
FIXED ASSETS						
12.00	Land	963,454	0	0	0	12.00
13.00	Land improvements	2,408,644	0	0	0	13.00
14.00	Accumulated depreciation	-1,806,256	0	0	0	14.00
15.00	Buildings	111,233,103	0	0	0	15.00
16.00	Accumulated depreciation	-51,293,814	0	0	0	16.00
17.00	Leasehold improvements	24,000	0	0	0	17.00
18.00	Accumulated depreciation	-24,000	0	0	0	18.00
19.00	Fixed equipment	5,428,884	0	0	0	19.00
20.00	Accumulated depreciation	-4,368,301	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	47,626,734	0	0	0	23.00
24.00	Accumulated depreciation	-29,050,438	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	130,739	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	81,272,749	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	41,211,939	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	914,608	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	42,126,547	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	289,118,543	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,266,898	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,937,345	0	0	0	38.00
39.00	Payroll taxes payable	160,505	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,226,680	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	8,487,638	0	0	0	43.00
44.00	Other current liabilities	15,089,348	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	39,168,414	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	33,058,838	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,596,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	53,654,838	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	92,823,252	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	196,295,291				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	196,295,291	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	289,118,543	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0289

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

Worksheet G-1

Date/Time Prepared:
5/31/2022 9:38 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		170,244,095		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43,851,256				2.00
3.00	Total (sum of line 1 and line 2)		214,095,351		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		214,095,351		0		11.00
12.00	TRANSFERS	17,800,060		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)		17,800,060		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		196,295,291		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS		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: 14-0289

Period:
From 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2022 9:38 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	55,305,459		55,305,459	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,850,772		2,850,772	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)	58,156,231		58,156,231	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,993,739		7,993,739	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)	7,993,739		7,993,739	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	66,149,970		66,149,970	17.00
18.00	Ancillary services	162,101,475	347,213,422	509,314,897	18.00
19.00	Outpatient services	26,755,388	95,410,445	122,165,833	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		1,802,518	1,802,518	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	958	958	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	255,006,833	444,427,343	699,434,176	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		155,164,484		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)		155,164,484		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0289

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

Worksheet G-3

Date/Time Prepared:
5/31/2022 9:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	699,434,176	1.00
2.00	Less contractual allowances and discounts on patients' accounts	529,348,965	2.00
3.00	Net patient revenues (line 1 minus line 2)	170,085,211	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	155,164,484	4.00
5.00	Net income from service to patients (line 3 minus line 4)	14,920,727	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	14,055,610	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	-37	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	64,316	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	220	21.00
22.00	Rental of hospital space	1,126,755	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC OTHER INCOME	692,497	24.00
24.50	COVID-19 PHE Funding	13,006,785	24.50
25.00	Total other income (sum of lines 6-24)	28,946,146	25.00
26.00	Total (line 5 plus line 25)	43,866,873	26.00
27.00	LOSS ON DISPOSAL OF INCOME	15,617	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	15,617	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	43,851,256	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0289

Period:

Worksheet H

HHA CCN: 14-7420

From 01/01/2021

Date/Time Prepared:

To 12/31/2021

5/31/2022 9:38 am

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures			0		0	0
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	0	0
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	257,035	0	0	0	21,993	279,028
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	650,795	0	23,184	0	0	673,979
7.00 Physical Therapy	238,183	0	13,076	0	0	251,259
8.00 Occupational Therapy	131,233	0	6,660	0	0	137,893
9.00 Speech Pathology	0	0	214	26,550	0	26,764
10.00 Medical Social Services	0	0	0	0	0	0
11.00 Home Health Aide	14,606	0	797	0	0	15,403
12.00 Supplies (see instructions)	0	0	0	0	34,597	34,597
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	1,291,852	0	43,931	26,550	56,590	1,418,923
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00 Capital Related - Movable Equipment	0	0	0	0		2.00
3.00 Plant Operation & Maintenance	0	0	0	0		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	0	279,028	0	279,028		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	673,979	0	673,979		6.00
7.00 Physical Therapy	0	251,259	0	251,259		7.00
8.00 Occupational Therapy	0	137,893	0	137,893		8.00
9.00 Speech Pathology	0	26,764	0	26,764		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Home Health Aide	0	15,403	0	15,403		11.00
12.00 Supplies (see instructions)	-27,636	6,961	0	6,961		12.00
13.00 Drugs	0	0	0	0		13.00
14.00 DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0		15.00
16.00 Respiratory Therapy	0	0	0	0		16.00
17.00 Private Duty Nursing	0	0	0	0		17.00
18.00 Clinic	0	0	0	0		18.00
19.00 Health Promotion Activities	0	0	0	0		19.00
20.00 Day Care Program	0	0	0	0		20.00
21.00 Home Delivered Meals Program	0	0	0	0		21.00
22.00 Homemaker Service	0	0	0	0		22.00
23.00 All Others (specify)	0	0	0	0		23.00
23.50 Telemedicine	0	0	0	0		23.50
24.00 Total (sum of lines 1-23)	-27,636	1,391,287	0	1,391,287		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0289

Period:

Worksheet H-1

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/31/2022 9:38 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	279,028	0	0	0	0	279,028	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	673,979	0	0	0	0	673,979	6.00
7.00	Physical Therapy	251,259	0	0	0	0	251,259	7.00
8.00	Occupational Therapy	137,893	0	0	0	0	137,893	8.00
9.00	Speech Pathology	26,764	0	0	0	0	26,764	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	15,403	0	0	0	0	15,403	11.00
12.00	Supplies (see instructions)	6,961	0	0	0	0	6,961	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,391,287	0	0	0	0	1,391,287	24.00
		Administrativ e & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	279,028						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	169,079	843,058					6.00
7.00	Physical Therapy	63,032	314,291					7.00
8.00	Occupational Therapy	34,593	172,486					8.00
9.00	Speech Pathology	6,714	33,478					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	3,864	19,267					11.00
12.00	Supplies (see instructions)	1,746	8,707					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,391,287					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-1

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/31/2022 9:38 amHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-279,028	1,112,259	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	673,979	6.00
7.00	Physical Therapy	0	0	0	0	0	251,259	7.00
8.00	Occupational Therapy	0	0	0	0	0	137,893	8.00
9.00	Speech Pathology	0	0	0	0	0	26,764	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	15,403	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	6,961	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-279,028	1,112,259	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		279,028	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.250866	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/31/2022 9:38 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	13,775	0	53,615	67,390	16,419	1.00
2.00	Skilled Nursing Care	843,058	0	0	135,748	978,806	238,478	2.00
3.00	Physical Therapy	314,291	0	0	49,682	363,973	88,679	3.00
4.00	Occupational Therapy	172,486	0	0	27,374	199,860	48,694	4.00
5.00	Speech Pathology	33,478	0	0	0	33,478	8,157	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	19,267	0	0	3,047	22,314	5,437	7.00
8.00	Supplies (see instructions)	8,707	0	0	0	8,707	2,121	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,391,287	13,775	0	269,466	1,674,528	407,985	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	12,581	18,260	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	12,581	18,260	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/31/2022 9:38 amHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	
		13.00	14.00	15.00	16.00	17.00	23.00	
1.00	Administrative and General	61,768	892	0	6,453	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	61,768	892	0	6,453	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	183,763	0	183,763				1.00
2.00	Skilled Nursing Care	1,217,284	0	1,217,284	111,919	1,329,203		2.00
3.00	Physical Therapy	452,652	0	452,652	41,617	494,269		3.00
4.00	Occupational Therapy	248,554	0	248,554	22,852	271,406		4.00
5.00	Speech Pathology	41,635	0	41,635	3,828	45,463		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	27,751	0	27,751	2,551	30,302		7.00
8.00	Supplies (see instructions)	10,828	0	10,828	996	11,824		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	2,182,467	0	2,182,467	183,763	2,182,467		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.091941			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/31/2022 9:38 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,736	0	257,035	0	67,390	1,736	1.00
2.00	Skilled Nursing Care	0	0	650,794	0	978,806	0	2.00
3.00	Physical Therapy	0	0	238,183	0	363,973	0	3.00
4.00	Occupational Therapy	0	0	131,233	0	199,860	0	4.00
5.00	Speech Pathology	0	0	0	0	33,478	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	14,606	0	22,314	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	8,707	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,736	0	1,291,851		1,674,528	1,736	20.00
21.00	Total cost to be allocated	13,775	0	269,466		407,985	12,581	21.00
22.00	Unit cost multiplier	7.934908	0.000000	0.208589		0.243642	7.247120	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,736	0	0	0	0	550	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,736	0	0	0	0	550	20.00
21.00	Total cost to be allocated	18,260	0	0	0	0	61,768	21.00
22.00	Unit cost multiplier	10.518433	0.000000	0.000000	0.000000	0.000000	112.305455	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289

Period:

Worksheet H-2

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/31/2022 9:38 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)		
		14.00	15.00	16.00	17.00	23.00		
1.00	Administrative and General	6,961	0	141	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	6,961	0	141	0	0		20.00
21.00	Total cost to be allocated	892	0	6,453	0	0		21.00
22.00	Unit cost multiplier	0.128143	0.000000	45.765957	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/31/2022 9:38 am

				Title XVIII		Home Health Agency I	PPS		
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	1,329,203		1,329,203	4,654	285.60	1.00	
2.00	Physical Therapy	3.00	494,269	0	494,269	2,625	188.29	2.00	
3.00	Occupational Therapy	4.00	271,406	0	271,406	1,337	203.00	3.00	
4.00	Speech Pathology	5.00	45,463	0	45,463	160	284.14	4.00	
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00	
6.00	Home Health Aide	7.00	30,302		30,302	43	704.70	6.00	
7.00	Total (sum of lines 1-6)		2,170,643	0	2,170,643	8,819		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Program Visits					
				Part A					
					Part B				
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		41180	0	1,948			8.00	
8.01	Skilled Nursing Care		44100	0	0			8.01	
9.00	Physical Therapy		41180	0	1,062			9.00	
9.01	Physical Therapy		44100	0	0			9.01	
10.00	Occupational Therapy		41180	0	548			10.00	
10.01	Occupational Therapy		44100	0	0			10.01	
11.00	Speech Pathology		41180	0	46			11.00	
11.01	Speech Pathology		44100	0	0			11.01	
12.00	Medical Social Services		41180	0	0			12.00	
12.01	Medical Social Services		44100	0	0			12.01	
13.00	Home Health Aide		41180	0	13			13.00	
13.01	Home Health Aide		44100	0	0			13.01	
14.00	Total (sum of lines 8-13)			0	3,617			14.00	
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	11,824	0	11,824	22,991	0.514288	15.00	
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00	
Cost Center Description		Program Visits			Cost of Services				
		Part A	Part B						
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B			
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0	1,948		0	556,349		1.00	
2.00	Physical Therapy	0	1,062		0	199,964		2.00	
3.00	Occupational Therapy	0	548		0	111,244		3.00	
4.00	Speech Pathology	0	46		0	13,070		4.00	
5.00	Medical Social Services	0	0		0	0		5.00	
6.00	Home Health Aide	0	13		0	9,161		6.00	
7.00	Total (sum of lines 1-6)	0	3,617		0	889,788		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/31/2022 9:38 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
14.00	Total (sum of lines 8-13)								14.00
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00		10.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0		15.00
16.00	Cost of Drugs		0	0		0	0		16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	556,349							1.00
2.00	Physical Therapy	199,964							2.00
3.00	Occupational Therapy	111,244							3.00
4.00	Speech Pathology	13,070							4.00
5.00	Medical Social Services	0							5.00
6.00	Home Health Aide	9,161							6.00
7.00	Total (sum of lines 1-6)	889,788							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289

Period:

Worksheet H-3

HHA CCN: 14-7420

From 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/31/2022 9:38 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.233627	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.306582	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.393467	0	0	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	0.190511	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.597242	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.195680	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0289 HHA CCN: 14-7420	Period: From 01/01/2021 To 12/31/2021	Worksheet H-4 Part I-II Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	626,615	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	84,162	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	17,671	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	25,021	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	753,469	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	753,469	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	753,469	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	753,469	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	753,469	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	753,469	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0289 HHA CCN: 14-7420		Period: From 01/01/2021 To 12/31/2021		Worksheet H-5 Date/Time Prepared: 5/31/2022 9:38 am	
				Home Health Agency I		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		0		753,469	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			0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50			0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		753,469	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			0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		753,469	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0289	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/31/2022 9:38 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,116,183	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,039	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)		66.42	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)		2.77	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		21.23	8.00
9.00	Sum of lines 7 and 8		24.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.98	10.00
11.00	Disproportionate share adjustment (see instructions)		55,586	11.00
12.00	Total prospective capital payments (see instructions)		1,177,808	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