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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/28/2022 9:17 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically prepared cost report — Date: 5/28/2022 Time: 9:17 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (15-1318) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-793,426	-1,045,198	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-144,586	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-938,012	-1,045,198	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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2022 9:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:			1.00
2.00	City: PERU	State: IN	Zip Code: 46970	County: MIAMI	2.00

		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	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	15Z318	99915		12/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2022 9:17 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	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.				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: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/28/2022 9:17 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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/28/2022 9:17 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		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)	N		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)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	15,152	20,547	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1848	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: COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2022 9:17 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	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	03/08/2022	Y	03/08/2022	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: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/28/2022 9:17 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.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2020	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.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REVENUE MANAGEMENT		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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2022 9:17 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	88,155.00	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)		21	7,665	88,155.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	17,421.00	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)		25	9,125	105,576.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2022 9:17 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)	1,545	91	3,673			1.00
2.00	HMO and other (see instructions)	334	710				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	724	0	1,020			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		16	235			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,269	107	4,928			7.00
8.00	INTENSIVE CARE UNIT	267	23	726			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		26	255			13.00
14.00	Total (see instructions)	2,536	156	5,909	0.00	199.48	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	199.48	27.00
28.00	Observation Bed Days		0	612			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2022 9:17 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	389	41	991	1.00
2.00	HMO and other (see instructions)			57	254		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	389	41	991	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2022 9:17 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	222,815	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,738,093	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	5,373	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,964	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)	8,284	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	120,242	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	771,182	17.00
18.00	Medicare Taxes - Employers Portion Only	180,357	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	31,331	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,085,641	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/28/2022 9:17 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)	0.189404	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,588,899	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	48,043,551	6.00
7.00	Medicaid cost (line 1 times line 6)	9,099,641	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,510,742	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,510,742	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)	2,839,250	0	2,839,250	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	537,765	0	537,765	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,321	0	2,321	22.00
23.00	Cost of charity care (line 21 minus line 22)	535,444	0	535,444	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)	4,507,826	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	468,214	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	720,329	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,787,497	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	969,482	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,504,926	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,015,668	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,068,389	1,068,389	961,662	2,030,051	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,033,164	3,033,164	273,191	3,306,355	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	112,741	66,021	178,762	2,115,353	2,294,115	4.00
5.01	00570	ADMITTING	0	0	0	1,333,403	1,333,403	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	1,874,549	10,373,936	12,248,485	-4,041,972	8,206,513	5.02
7.00	00700	OPERATION OF PLANT	318,798	1,662,448	1,981,246	577,189	2,558,435	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	81,911	81,911	0	81,911	8.00
9.00	00900	HOUSEKEEPING	414,706	159,577	574,283	-3,056	571,227	9.00
10.00	01000	DIETARY	238,813	160,551	399,364	-169,123	230,241	10.00
11.00	01100	CAFETERIA	0	0	0	166,275	166,275	11.00
13.00	01300	NURSING ADMINISTRATION	414,653	106,117	520,770	-229,815	290,955	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,898	224,812	333,710	-101,140	232,570	14.00
15.00	01500	PHARMACY	521,567	2,159,344	2,680,911	-2,030,091	650,820	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,912	275,037	332,949	-284	332,665	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	220,349	220,349	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,966,464	966,528	3,932,992	-296,405	3,636,587	30.00
31.00	03100	INTENSIVE CARE UNIT	583,350	445,907	1,029,257	-1,978	1,027,279	31.00
43.00	04300	NURSERY	0	0	0	284,291	284,291	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	459,484	376,239	835,723	-152,941	682,782	50.00
51.00	05100	RECOVERY ROOM	199,543	99,724	299,267	-693	298,574	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	278,356	278,356	0	278,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	451,780	313,617	765,397	232,533	997,930	54.00
54.01	05401	ULTRASOUND	105,139	55,133	160,272	-160,272	0	54.01
56.00	05600	RADIOISOTOPE	60,967	78,571	139,538	-139,538	0	56.00
57.00	05700	CT SCAN	129,367	239,046	368,413	-368,413	0	57.00
58.00	05800	MRI	89,653	215,071	304,724	-304,724	0	58.00
60.00	06000	LABORATORY	792,205	1,132,240	1,924,445	-62,381	1,862,064	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	59,083	59,083	0	59,083	62.00
65.00	06500	RESPIRATORY THERAPY	724,649	174,999	899,648	-48,367	851,281	65.00
66.00	06600	PHYSICAL THERAPY	0	375,871	375,871	-170	375,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	159,940	159,940	0	159,940	67.00
68.00	06800	SPEECH PATHOLOGY	0	48,114	48,114	0	48,114	68.00
69.00	06900	ELECTROCARDIOLOGY	200,610	23,091	223,701	-2,332	221,369	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,488	16,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,158	32,158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,947,031	1,947,031	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	103,367	13,169	116,536	-338	116,198	90.00
91.00	09100	EMERGENCY	3,515,305	1,380,189	4,895,494	-4,906	4,890,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	339,186	255,844	595,030	-40,489	554,541	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,783,706	26,062,039	40,845,745	495	40,846,240	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	314	3,736	4,050	-495	3,555	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	14,784,020	26,065,775	40,849,795	0	40,849,795	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/28/2022 9:17 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	422,230	2,452,281	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-596,883	2,709,472	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,294,115	4.00
5.01	00570	ADMITTING	0	1,333,403	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-509,464	7,697,049	5.02
7.00	00700	OPERATION OF PLANT	-11,575	2,546,860	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	81,911	8.00
9.00	00900	HOUSEKEEPING	0	571,227	9.00
10.00	01000	DIETARY	0	230,241	10.00
11.00	01100	CAFETERIA	-55,387	110,888	11.00
13.00	01300	NURSING ADMINISTRATION	-5,900	285,055	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	232,570	14.00
15.00	01500	PHARMACY	0	650,820	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-285	332,380	16.00
17.00	01700	SOCIAL SERVICE	0	220,349	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-315,562	3,321,025	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,027,279	31.00
43.00	04300	NURSERY	0	284,291	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	682,782	50.00
51.00	05100	RECOVERY ROOM	0	298,574	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-278,356	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	997,930	54.00
54.01	05401	ULTRASOUND	0	0	54.01
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
60.00	06000	LABORATORY	0	1,862,064	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	59,083	62.00
65.00	06500	RESPIRATORY THERAPY	0	851,281	65.00
66.00	06600	PHYSICAL THERAPY	0	375,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	159,940	67.00
68.00	06800	SPEECH PATHOLOGY	0	48,114	68.00
69.00	06900	ELECTROCARDIOLOGY	0	221,369	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,947,031	73.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	116,198	90.00
91.00	09100	EMERGENCY	-774,943	4,115,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	554,541	95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,126,125	38,720,115	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,555	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,126,125	38,723,670	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,115,582	1.00
	0		0	2,115,582	
	B - RENT AND LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	464,262	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	242,724	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
	0		0	706,986	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	132,230	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	365,170	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	30,467	3.00
	0		0	527,867	
	D - CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	177,436	0	1.00
	0		177,436	0	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16,488	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	32,158	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,775	3.00
4.00		0.00	0	0	4.00
	0		0	62,421	
	F - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,947,031	1.00
	0		0	1,947,031	
	G - NURSERY				
1.00	NURSERY	43.00	229,673	54,618	1.00
	0		229,673	54,618	
	I - MISC DEPARTMENTS				
1.00	ADMITTING	5.01	494,803	838,600	1.00
	0		494,803	838,600	
	J - OTHER RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	385,126	101,452	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
	0		385,126	101,452	
	K - DIETARY COSTS TO CAFETERIA				
1.00	CAFETERIA	11.00	100,144	66,131	1.00
	0		100,144	66,131	
	M - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	598,519	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00

RECLASSIFICATIONS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/28/2022 9:17 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	0		0	598,519	
	N - CASE MANAGEMENT				
1.00	ADMINISTRATIVE AND GENERAL	5.02	154,480	31,993	1.00
2.00	SOCIAL SERVICE	17.00	167,072	53,277	2.00
	0		321,552	85,270	
	O - NON CAPITALIZED EQUIPMENT				
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	16,103	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
	0		0	16,103	
500.00	Grand Total: Increases		1,708,734	7,120,580	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	2,115,582	0	1.00
	0		0	2,115,582		
	B - RENT AND LEASES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	229	10	1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	2,130	10	2.00
3.00	OPERATION OF PLANT	7.00	0	6,728	0	3.00
4.00	DIETARY	10.00	0	230	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	429	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	87,347	0	6.00
7.00	PHARMACY	15.00	0	64,506	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	283	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	630	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	169	0	10.00
11.00	OPERATING ROOM	50.00	0	55,558	0	11.00
12.00	RECOVERY ROOM	51.00	0	376	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	172,075	0	13.00
14.00	ULTRASOUND	54.01	0	33,243	0	14.00
15.00	CT SCAN	57.00	0	97,655	0	15.00
16.00	MRI	58.00	0	134,101	0	16.00
17.00	LABORATORY	60.00	0	13,604	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	33,777	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	169	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	1,044	0	20.00
21.00	CLINIC	90.00	0	338	0	21.00
22.00	EMERGENCY	91.00	0	437	0	22.00
23.00	AMBULANCE SERVICES	95.00	0	1,919	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9	0	24.00
	0		0	706,986		
	C - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	527,867	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	527,867		
	D - CNO COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	177,436	0	0	1.00
	0		177,436	0		
	E - MEDICAL SUPPLIES					
1.00	INTENSIVE CARE UNIT	31.00	0	1,335	0	1.00
2.00	OPERATING ROOM	50.00	0	60,527	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	101	0	3.00
4.00	EMERGENCY	91.00	0	458	0	4.00
	0		0	62,421		
	F - COST OF DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	1,947,031	0	1.00
	0		0	1,947,031		
	G - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	229,673	54,618	0	1.00
	0		229,673	54,618		
	I - MISC DEPARTMENTS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	494,803	838,600	0	1.00
	0		494,803	838,600		
	J - OTHER RADIOLOGY					
1.00	ULTRASOUND	54.01	105,139	8,740	0	1.00
2.00	RADIOISOTOPE	56.00	60,967	49,840	0	2.00
3.00	CT SCAN	57.00	129,367	35,953	0	3.00
4.00	MRI	58.00	89,653	6,919	0	4.00
	0		385,126	101,452		
	K - DIETARY COSTS TO CAFETERIA					
1.00	DIETARY	10.00	100,144	66,131	0	1.00
	0		100,144	66,131		
	M - REPAIRS AND MAINTENANCE					
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	88,130	0	1.00
2.00	HOUSEKEEPING	9.00	0	2,676	0	2.00
3.00	DIETARY	10.00	0	2,618	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	27,568	0	4.00
5.00	PHARMACY	15.00	0	18,554	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	11,107	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	474	0	8.00
9.00	OPERATING ROOM	50.00	0	36,651	0	9.00
10.00	RECOVERY ROOM	51.00	0	317	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	81,970	0	11.00
12.00	ULTRASOUND	54.01	0	13,150	0	12.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	RADIOISOTOPE	56.00	0	28,731	0		13.00
14.00	CT SCAN	57.00	0	105,438	0		14.00
15.00	MRI	58.00	0	73,755	0		15.00
16.00	LABORATORY	60.00	0	48,534	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	14,489	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	1	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	1,288	0		19.00
20.00	EMERGENCY	91.00	0	4,011	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	38,570	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	486	0		22.00
	0		0	598,519			
	N - CASE MANAGEMENT						
1.00	NURSING ADMINISTRATION	13.00	321,552	85,270	0		1.00
2.00		0.00	0	0	0		2.00
	0		321,552	85,270			
	O - NON CAPITALIZED EQUIPMENT						
1.00	OPERATION OF PLANT	7.00	0	14,602	0		1.00
2.00	HOUSEKEEPING	9.00	0	380	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	377	0		3.00
4.00	OPERATING ROOM	50.00	0	205	0		4.00
5.00	MRI	58.00	0	296	0		5.00
6.00	LABORATORY	60.00	0	243	0		6.00
	0		0	16,103			
500.00	Grand Total: Decreases		1,708,734	7,120,580			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2022 9:17 am

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	193,225	0	0	0	0	1.00
2.00	Land Improvements	1,038,384	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,885,797	1,136,653	0	1,136,653	1,270,475	3.00
4.00	Building Improvements	33,426,837	284,450	0	284,450	1,760,995	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	4,602,668	42,391	0	42,391	52,130	7.00
8.00	Subtotal (sum of lines 1-7)	68,146,911	1,463,494	0	1,463,494	3,083,600	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	68,146,911	1,463,494	0	1,463,494	3,083,600	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	193,225	0	1.00
2.00	Land Improvements	1,038,384	0	2.00
3.00	Buildings and Fixtures	28,751,975	0	3.00
4.00	Building Improvements	31,950,292	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	4,592,929	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,526,805	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	66,526,805	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1318

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

Worksheet A-7 Part II

Date/Time Prepared: 5/28/2022 9:17 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,068,389	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,033,164	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,101,553	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,068,389	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,033,164	2.00
3.00	Total (sum of lines 1-2)	0	4,101,553	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III | Date/Time Prepared: 5/28/2022 9:17 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	61,933,876	0	61,933,876	0.930961	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,592,929	0	4,592,929	0.069039	0	2.00
3.00	Total (sum of lines 1-2)	66,526,805	0	66,526,805	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,444,656	508,089	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,334,074	344,669	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,778,730	852,758	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,136	132,230	365,170	0	2,452,281	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	262	30,467	0	0	2,709,472	2.00
3.00	Total (sum of lines 1-2)	2,398	162,697	365,170	0	5,161,753	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/28/2022 9:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,665	ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-11,575	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	-1,368,861			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	-330,484			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-55,387	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-285	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-184	ADMINISTRATIVE AND GENERAL	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-1,346	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-719,034	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-3,725	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/28/2022 9:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	FITNESS REVENUE	B	135	ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	MISCELLANEOUS INCOME	B	-14,929	ADMINISTRATIVE AND GENERAL	5.02	0	33.02
33.03	PATIENT PHONE DEPRECIATION	A	-36	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04	PATIENT TV DEPRECIATION	A	-934	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	EMPLOYEE SELF INS DISCOUNTS	B	28,162	ADMINISTRATIVE AND GENERAL	5.02	0	33.05
33.06	INSERVICE EDUCATION	B	-2,175	NURSING ADMINISTRATION	13.00	0	33.06
33.07	POB CAPITAL RELATED EXPENSE	A	377,613	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	POB CAPITAL RELATED EXPENSE	A	20,914	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	CHARITABLE CONTRIBUTIONS	A	-1,720	ADMINISTRATIVE AND GENERAL	5.02	0	33.09
34.00	INTEREST INCOME ADD BACK	B	2,507	ADMINISTRATIVE AND GENERAL	5.02	0	34.00
35.00	MARKETING EXPENSE	A	-31,472	ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	PENALTIES	A	-164	ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	LOBBYING EXPENSE	A	-73	ADMINISTRATIVE AND GENERAL	5.02	0	37.00
40.00	PHYSICIAN RECRUITING	A	-9,407	ADMINISTRATIVE AND GENERAL	5.02	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,126,125				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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2022 9:17 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	0.00		PASI CAPITAL COSTS - BLDG &	0	0	1.00
2.00	0.00		PASI CAPITAL COSTS - MOVEABL	0	0	2.00
3.00	0.00		PASI OPERATING COSTS	0	0	3.00
3.02	0.00		SHARED SERVICE CENTER ALLOCA	0	0	3.02
3.04	0.00		NEW CAPITAL - BUILDING AND F	0	0	3.04
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	2,136	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	262	0	4.01
4.02	5.02	ADMINISTRATIVE AND GENERAL	PASI Operating Costs	181,302	215,060	4.02
4.03	5.02	ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca	851,980	691,725	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	43,827	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	101,945	0	4.05
4.06	5.02	ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	1,097,829	0	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	Malpractice Costs	35,699	208,368	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	Management Fees	0	856,509	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	401K Fees	0	4,400	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	Audit Fees	0	21,252	4.10
4.11	5.02	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	438,599	4.11
4.12	5.02	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	169,801	4.12
4.13	5.02	ADMINISTRATIVE AND GENERAL	Contract Management	0	12,438	4.13
4.14	5.02	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	27,312	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,314,980	2,645,464	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		
	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	B		0.00	HOSPITAL LAUNDRY SERVICE	100.00	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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2022 9:17 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	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
3.02	0	0	3.02
3.04	0	0	3.04
4.00	2,136	11	4.00
4.01	262	11	4.01
4.02	-33,758	0	4.02
4.03	160,255	0	4.03
4.04	43,827	10	4.04
4.05	101,945	10	4.05
4.06	1,097,829	0	4.06
4.07	-172,669	0	4.07
4.08	-856,509	0	4.08
4.09	-4,400	0	4.09
4.10	-21,252	0	4.10
4.11	-438,599	0	4.11
4.12	-169,801	0	4.12
4.13	-12,438	0	4.13
4.14	-27,312	0	4.14
5.00	-330,484		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	HOSPITAL MANAGEMENT	6.00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY SERVICE	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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2022 9:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	315,562	315,562	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	278,356	278,356	0	0	0	2.00
3.00	91.00	EMERGENCY	774,943	774,943	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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			1,368,861	1,368,861	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	315,562	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	278,356	2.00
3.00	91.00	EMERGENCY	0	0	0	774,943	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,368,861	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/28/2022 9:17 am

Physical Therapy | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	0	1.00
2.00	Line 1 multiplied by 15 hours per week	0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,173.19	3,449.74	1,029.71	1,177.47	0.00	9.00
10.00	AHSEA (see instructions)	81.04	81.04	50.50	17.50	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.52	40.52	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	95,075	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	279,567	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	52,000	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	426,642	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	20,606	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	447,248	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	447,248	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/28/2022 9:17 am
		Physical Therapy	Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.04	50.50	17.50	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	447,248	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	447,248	63.00
64.00	Total cost of outside supplier services (from your records)	374,446	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2022 9:17 am

Occupational Therapy | Cost

Line	Description	1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	0	1.00
2.00	Line 1 multiplied by 15 hours per week	0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

Line	Description	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	Total hours worked	0.00	2,123.59	251.45	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.82	50.50	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.41	38.41	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

Line	Description	1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	163,134	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	12,698	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	175,832	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	175,832	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	175,832	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2022 9:17 am

Occupational Therapy | Cost

		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.82	50.50	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	175,832	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	175,832	63.00
64.00	Total cost of outside supplier services (from your records)	159,940	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/28/2022 9:17 am

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	0	1.00
2.00	Line 1 multiplied by 15 hours per week	0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	685.88	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.84	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.92	36.92	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	50,645	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	50,645	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	50,645	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	50,645	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2022 9:17 am

Speech Pathology | Cost

		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.84	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	50,645	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	50,645	63.00
64.00	Total cost of outside supplier services (from your records)	48,115	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,452,281	2,452,281				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,709,472		2,709,472			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,294,115	11,187	12,361	2,317,663		4.00
5.01	00570	ADMITTING	1,333,403	18,024	19,914	78,166	1,449,507	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	7,697,049	151,624	167,526	214,336	0	5.02
7.00	00700	OPERATION OF PLANT	2,546,860	664,845	734,571	50,361	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,911	28,970	32,009	0	0	8.00
9.00	00900	HOUSEKEEPING	571,227	27,968	30,901	65,512	0	9.00
10.00	01000	DIETARY	230,241	35,959	39,730	21,906	0	10.00
11.00	01100	CAFETERIA	110,888	32,293	35,680	15,820	0	11.00
13.00	01300	NURSING ADMINISTRATION	285,055	8,879	9,810	42,738	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232,570	45,104	49,835	17,203	0	14.00
15.00	01500	PHARMACY	650,820	26,053	28,785	82,394	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	332,380	42,162	46,583	9,149	0	16.00
17.00	01700	SOCIAL SERVICE	220,349	10,959	12,108	26,393	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,321,025	347,718	384,187	432,339	91,739	30.00
31.00	03100	INTENSIVE CARE UNIT	1,027,279	43,734	48,321	92,154	19,121	31.00
43.00	04300	NURSERY	284,291	9,500	10,497	36,282	1,554	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	682,782	164,676	181,947	72,586	100,722	50.00
51.00	05100	RECOVERY ROOM	298,574	12,963	14,323	31,522	21,499	51.00
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	997,930	138,775	153,330	132,209	296,858	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	1,862,064	38,952	43,038	125,147	201,048	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	59,083	1,497	1,654	0	3,275	62.00
65.00	06500	RESPIRATORY THERAPY	851,281	39,358	43,486	114,475	49,284	65.00
66.00	06600	PHYSICAL THERAPY	375,701	112,304	124,082	0	18,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	159,940	3,057	3,377	0	8,774	67.00
68.00	06800	SPEECH PATHOLOGY	48,114	0	0	0	1,096	68.00
69.00	06900	ELECTROCARDIOLOGY	221,369	51,560	56,968	31,691	51,417	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,488	0	0	0	30,428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,158	0	0	0	2,420	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,947,031	0	0	0	249,615	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	116,198	34,475	38,091	16,329	1,263	90.00
91.00	09100	EMERGENCY	4,115,645	93,468	103,271	555,319	221,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	554,541	32,433	35,834	53,582	79,582	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,720,115	2,228,497	2,462,219	2,317,613	1,449,507	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,970	11,015	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,555	213,814	236,238	50	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,723,670	2,452,281	2,709,472	2,317,663	1,449,507	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	8,230,535	8,230,535				5.02
7.00	00700	OPERATION OF PLANT	3,996,637	1,078,748	5,075,385			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,890	38,568	105,569	287,027		8.00
9.00	00900	HOUSEKEEPING	695,608	187,754	101,917	0	985,279	9.00
10.00	01000	DIETARY	327,836	88,488	131,036	0	27,182	10.00
11.00	01100	CAFETERIA	194,681	52,547	117,679	0	24,411	11.00
13.00	01300	NURSING ADMINISTRATION	346,482	93,520	32,355	0	6,712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	344,712	93,043	164,362	0	34,095	14.00
15.00	01500	PHARMACY	788,052	212,706	94,938	0	19,694	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	430,274	116,137	153,638	0	31,871	16.00
17.00	01700	SOCIAL SERVICE	269,809	72,825	39,935	0	8,284	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,577,008	1,235,399	1,267,100	226,525	262,848	30.00
31.00	03100	INTENSIVE CARE UNIT	1,230,609	332,159	159,370	44,775	33,060	31.00
43.00	04300	NURSERY	342,124	92,344	34,619	15,727	7,181	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,202,713	324,629	600,087	0	124,482	50.00
51.00	05100	RECOVERY ROOM	378,881	102,265	47,238	0	9,799	51.00
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	1,719,102	464,010	505,704	0	104,903	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	2,270,249	612,772	141,945	0	29,445	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,509	17,682	5,454	0	1,131	62.00
65.00	06500	RESPIRATORY THERAPY	1,097,884	296,334	143,424	0	29,752	65.00
66.00	06600	PHYSICAL THERAPY	630,157	170,088	409,240	0	84,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,148	47,275	11,139	0	2,311	67.00
68.00	06800	SPEECH PATHOLOGY	49,210	13,282	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	413,005	111,476	187,888	0	38,975	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,916	12,663	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,578	9,333	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,196,646	592,906	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	206,356	55,698	125,629	0	26,060	90.00
91.00	09100	EMERGENCY	5,089,445	1,373,725	340,602	0	70,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	755,972	204,047	118,187	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,249,028	8,102,423	5,039,055	287,027	977,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,985	5,664	36,330	0	7,536	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	453,657	122,448	0	0	0	192.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,723,670	8,230,535	5,075,385	287,027	985,279	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	574,542					10.00
11.00	01100	CAFETERIA	0	389,318				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,558	484,627			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,782	0	642,994		14.00
15.00	01500	PHARMACY	0	13,430	0	24,278	1,153,098	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,255	0	399	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,346	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	479,721	100,927	257,455	75,431	0	30.00
31.00	03100	INTENSIVE CARE UNIT	94,821	17,419	53,901	12,552	0	31.00
43.00	04300	NURSERY	0	6,595	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,691	23,964	85,423	0	50.00
51.00	05100	RECOVERY ROOM	0	5,292	17,864	9,070	0	51.00
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	34,573	1,169	25,582	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	39,360	11	242,630	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	26,676	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	25,850	0	33,499	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	558	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,207	0	2,645	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,902	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,061	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,153,098	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,165	8,819	2,525	0	90.00
91.00	09100	EMERGENCY	0	39,626	121,444	43,944	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	58,242	0	35,811	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	574,542	389,318	484,627	642,986	1,153,098	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	8	0	192.00
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)	574,542	389,318	484,627	642,994	1,153,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	736,574					16.00
17.00	01700	SOCIAL SERVICE	0	396,199				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,620	312,686	8,841,720	0	8,841,720	30.00
31.00	03100	INTENSIVE CARE UNIT	9,717	61,805	2,050,188	0	2,050,188	31.00
43.00	04300	NURSERY	790	21,708	521,088	0	521,088	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,185	0	2,428,174	0	2,428,174	50.00
51.00	05100	RECOVERY ROOM	10,926	0	581,335	0	581,335	51.00
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	150,817	0	3,005,860	0	3,005,860	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	102,169	0	3,438,581	0	3,438,581	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,664	0	118,116	0	118,116	62.00
65.00	06500	RESPIRATORY THERAPY	25,045	0	1,651,788	0	1,651,788	65.00
66.00	06600	PHYSICAL THERAPY	9,183	0	1,304,119	0	1,304,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,459	0	240,332	0	240,332	67.00
68.00	06800	SPEECH PATHOLOGY	557	0	63,049	0	63,049	68.00
69.00	06900	ELECTROCARDIOLOGY	26,129	0	787,325	0	787,325	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,463	0	81,944	0	81,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,230	0	60,202	0	60,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,850	0	4,069,500	0	4,069,500	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	642	0	428,894	0	428,894	90.00
91.00	09100	EMERGENCY	112,686	0	7,192,126	0	7,192,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	40,442	0	1,212,701	0	1,212,701	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	736,574	396,199	38,077,042	0	38,077,042	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	70,515	0	70,515	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	576,113	0	576,113	192.00
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)	736,574	396,199	38,723,670	0	38,723,670	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	11,187	12,361	23,548	23,548	4.00
5.01	00570	ADMITTING	0	18,024	19,914	37,938	794	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	151,624	167,526	319,150	2,178	5.02
7.00	00700	OPERATION OF PLANT	0	664,845	734,571	1,399,416	512	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,970	32,009	60,979	0	8.00
9.00	00900	HOUSEKEEPING	0	27,968	30,901	58,869	666	9.00
10.00	01000	DIETARY	0	35,959	39,730	75,689	223	10.00
11.00	01100	CAFETERIA	0	32,293	35,680	67,973	161	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,879	9,810	18,689	434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,104	49,835	94,939	175	14.00
15.00	01500	PHARMACY	0	26,053	28,785	54,838	837	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,162	46,583	88,745	93	16.00
17.00	01700	SOCIAL SERVICE	0	10,959	12,108	23,067	268	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	347,718	384,187	731,905	4,393	30.00
31.00	03100	INTENSIVE CARE UNIT	0	43,734	48,321	92,055	936	31.00
43.00	04300	NURSERY	0	9,500	10,497	19,997	369	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	164,676	181,947	346,623	737	50.00
51.00	05100	RECOVERY ROOM	0	12,963	14,323	27,286	320	51.00
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	138,775	153,330	292,105	1,343	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	38,952	43,038	81,990	1,271	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,497	1,654	3,151	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,358	43,486	82,844	1,163	65.00
66.00	06600	PHYSICAL THERAPY	0	112,304	124,082	236,386	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,057	3,377	6,434	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	51,560	56,968	108,528	322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	34,475	38,091	72,566	166	90.00
91.00	09100	EMERGENCY	0	93,468	103,271	196,739	5,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	32,433	35,834	68,267	544	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,228,497	2,462,219	4,690,716	23,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,970	11,015	20,985	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	213,814	236,238	450,052	1	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,452,281	2,709,472	5,161,753	23,548	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	ADMITTING	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	38,732					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	321,328				5.02
7.00	00700	OPERATION OF PLANT	0	42,117	1,442,045			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,506	29,995	92,480		8.00
9.00	00900	HOUSEKEEPING	0	7,330	28,957	0	95,822	9.00
10.00	01000	DIETARY	0	3,455	37,231	0	2,644	10.00
11.00	01100	CAFETERIA	0	2,052	33,435	0	2,374	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,651	9,193	0	653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,633	46,699	0	3,316	14.00
15.00	01500	PHARMACY	0	8,304	26,974	0	1,915	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,534	43,653	0	3,100	16.00
17.00	01700	SOCIAL SERVICE	0	2,843	11,347	0	806	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,456	48,233	360,015	72,987	25,563	30.00
31.00	03100	INTENSIVE CARE UNIT	512	12,968	45,281	14,426	3,215	31.00
43.00	04300	NURSERY	42	3,605	9,836	5,067	698	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,696	12,674	170,500	0	12,106	50.00
51.00	05100	RECOVERY ROOM	576	3,993	13,421	0	953	51.00
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	7,875	18,116	143,683	0	10,202	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	5,382	23,924	40,330	0	2,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	88	690	1,550	0	110	62.00
65.00	06500	RESPIRATORY THERAPY	1,319	11,570	40,750	0	2,893	65.00
66.00	06600	PHYSICAL THERAPY	484	6,641	116,276	0	8,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	235	1,846	3,165	0	225	67.00
68.00	06800	SPEECH PATHOLOGY	29	519	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,376	4,352	53,384	0	3,791	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	815	494	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65	364	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,682	23,148	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	34	2,175	35,694	0	2,534	90.00
91.00	09100	EMERGENCY	5,936	53,623	96,774	0	6,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,130	7,966	33,580	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,732	316,326	1,431,723	92,480	95,089	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	221	10,322	0	733	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,781	0	0	0	192.00
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)	38,732	321,328	1,442,045	92,480	95,822	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	119,242					10.00
11.00	01100	CAFETERIA	0	105,995				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,513	34,133			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,846	0	150,608		14.00
15.00	01500	PHARMACY	0	3,656	0	5,687	102,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,158	0	93	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,455	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,563	27,479	18,134	17,668	0	30.00
31.00	03100	INTENSIVE CARE UNIT	19,679	4,743	3,796	2,940	0	31.00
43.00	04300	NURSERY	0	1,796	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,272	1,688	20,009	0	50.00
51.00	05100	RECOVERY ROOM	0	1,441	1,258	2,125	0	51.00
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	9,413	82	5,992	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	10,716	1	56,829	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,248	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,038	0	7,847	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	131	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,962	0	620	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,617	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,528	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	102,211	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	862	621	591	0	90.00
91.00	09100	EMERGENCY	0	10,788	8,553	10,293	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,857	0	8,388	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,242	105,995	34,133	150,606	102,211	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	2	0	192.00
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)	119,242	105,995	34,133	150,608	102,211	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	141,376					16.00
17.00	01700	SOCIAL SERVICE	0	39,786				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,945	31,400	1,448,741	0	1,448,741	30.00
31.00	03100	INTENSIVE CARE UNIT	1,864	6,206	208,621	0	208,621	31.00
43.00	04300	NURSERY	152	2,180	43,742	0	43,742	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,821	0	581,126	0	581,126	50.00
51.00	05100	RECOVERY ROOM	2,096	0	53,469	0	53,469	51.00
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	28,988	0	517,799	0	517,799	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	19,603	0	242,910	0	242,910	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	319	0	12,156	0	12,156	62.00
65.00	06500	RESPIRATORY THERAPY	4,805	0	160,229	0	160,229	65.00
66.00	06600	PHYSICAL THERAPY	1,762	0	369,936	0	369,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	856	0	12,761	0	12,761	67.00
68.00	06800	SPEECH PATHOLOGY	107	0	655	0	655	68.00
69.00	06900	ELECTROCARDIOLOGY	5,013	0	179,348	0	179,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,967	0	5,893	0	5,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	236	0	4,193	0	4,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,338	0	156,379	0	156,379	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	123	0	115,366	0	115,366	90.00
91.00	09100	EMERGENCY	21,621	0	416,840	0	416,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	7,760	0	144,492	0	144,492	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,376	39,786	4,674,656	0	4,674,656	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	32,261	0	32,261	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	454,836	0	454,836	192.00
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)	141,376	39,786	5,161,753	0	5,161,753	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	193,337					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		193,337				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	882	882	14,671,279			4.00
5.01	00570	ADMITTING	1,421	1,421	494,803	201,035,873		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	11,954	11,954	1,356,790	0	-8,230,535	5.02
7.00	00700	OPERATION OF PLANT	52,416	52,416	318,798	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,284	2,284	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,205	2,205	414,706	0	0	9.00
10.00	01000	DIETARY	2,835	2,835	138,669	0	0	10.00
11.00	01100	CAFETERIA	2,546	2,546	100,144	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	700	700	270,537	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,556	3,556	108,898	0	0	14.00
15.00	01500	PHARMACY	2,054	2,054	521,567	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,324	3,324	57,912	0	0	16.00
17.00	01700	SOCIAL SERVICE	864	864	167,072	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,414	27,414	2,736,791	12,723,822	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,448	3,448	583,350	2,651,999	0	31.00
43.00	04300	NURSERY	749	749	229,673	215,567	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,983	12,983	459,484	13,969,756	0	50.00
51.00	05100	RECOVERY ROOM	1,022	1,022	199,543	2,981,876	0	51.00
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	10,941	10,941	836,906	41,167,604	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	3,071	3,071	792,205	27,884,663	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118	118	0	454,271	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,103	3,103	724,649	6,835,531	0	65.00
66.00	06600	PHYSICAL THERAPY	8,854	8,854	0	2,506,256	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	241	241	0	1,216,936	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	151,979	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,065	4,065	200,610	7,131,290	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,220,271	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	335,697	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,620,605	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,718	2,718	103,367	175,147	0	90.00
91.00	09100	EMERGENCY	7,369	7,369	3,515,305	30,754,851	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,557	2,557	339,186	11,037,752	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175,694	175,694	14,670,965	201,035,873	-8,230,535	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	786	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,857	16,857	314	0	0	192.00
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)	2,452,281	2,709,472	2,317,663	1,449,507		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.683972	14.014245	0.157973	0.007210		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,548	38,732		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001605	0.000193		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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	30,493,135					5.02
7.00	00700	OPERATION OF PLANT	3,996,637	109,807				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,890	2,284	4,654			8.00
9.00	00900	HOUSEKEEPING	695,608	2,205	0	102,761		9.00
10.00	01000	DIETARY	327,836	2,835	0	2,835	4,399	10.00
11.00	01100	CAFETERIA	194,681	2,546	0	2,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	346,482	700	0	700	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	344,712	3,556	0	3,556	0	14.00
15.00	01500	PHARMACY	788,052	2,054	0	2,054	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	430,274	3,324	0	3,324	0	16.00
17.00	01700	SOCIAL SERVICE	269,809	864	0	864	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,577,008	27,414	3,673	27,414	3,673	30.00
31.00	03100	INTENSIVE CARE UNIT	1,230,609	3,448	726	3,448	726	31.00
43.00	04300	NURSERY	342,124	749	255	749	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,202,713	12,983	0	12,983	0	50.00
51.00	05100	RECOVERY ROOM	378,881	1,022	0	1,022	0	51.00
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	1,719,102	10,941	0	10,941	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	2,270,249	3,071	0	3,071	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,509	118	0	118	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,097,884	3,103	0	3,103	0	65.00
66.00	06600	PHYSICAL THERAPY	630,157	8,854	0	8,854	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,148	241	0	241	0	67.00
68.00	06800	SPEECH PATHOLOGY	49,210	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	413,005	4,065	0	4,065	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,916	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,578	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,196,646	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	206,356	2,718	0	2,718	0	90.00
91.00	09100	EMERGENCY	5,089,445	7,369	0	7,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	755,972	2,557	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,018,493	109,021	4,654	101,975	4,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,985	786	0	786	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	453,657	0	0	0	0	192.00
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)	8,230,535	5,075,385	287,027	985,279	574,542	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.269914	46.220960	61.673184	9.588064	130.607411	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	321,328	1,442,045	92,480	95,822	119,242	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.010538	13.132542	19.871079	0.932474	27.106615	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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	14,639					11.00
13.00	01300	NURSING ADMINISTRATION	209	5,294,202				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	255	0	1,424,151			14.00
15.00	01500	PHARMACY	505	0	53,772	1,947,031		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160	0	883	0	201,035,873	16.00
17.00	01700	SOCIAL SERVICE	201	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,795	2,812,518	167,070	0	12,723,822	30.00
31.00	03100	INTENSIVE CARE UNIT	655	588,828	27,800	0	2,651,999	31.00
43.00	04300	NURSERY	248	0	0	0	215,567	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	590	261,785	189,201	0	13,969,756	50.00
51.00	05100	RECOVERY ROOM	199	195,148	20,090	0	2,981,876	51.00
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	1,300	12,774	56,661	0	41,167,604	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	1,480	116	537,399	0	27,884,663	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	59,083	0	454,271	62.00
65.00	06500	RESPIRATORY THERAPY	972	0	74,197	0	6,835,531	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,235	0	2,506,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,216,936	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	151,979	68.00
69.00	06900	ELECTROCARDIOLOGY	271	0	5,859	0	7,131,290	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	15,288	0	4,220,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	33,358	0	335,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,947,031	34,620,605	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	119	96,345	5,592	0	175,147	90.00
91.00	09100	EMERGENCY	1,490	1,326,688	97,330	0	30,754,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,190	0	79,316	0	11,037,752	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,639	5,294,202	1,424,134	1,947,031	201,035,873	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	17	0	0	192.00
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)	389,318	484,627	642,994	1,153,098	736,574	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.594576	0.091539	0.451493	0.592234	0.003664	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	105,995	34,133	150,608	102,211	141,376	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.240590	0.006447	0.105753	0.052496	0.000703	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: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/28/2022 9:17 am

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			17.00	
	GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL		5.02
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	4,654	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,673	30.00
31.00	03100	INTENSIVE CARE UNIT	726	31.00
43.00	04300	NURSERY	255	43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
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
54.01	05401	ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
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
69.00	06900	ELECTROCARDIOLOGY	0	69.00
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
76.00	03610	SLEEP LAB	0	76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	95.00
	SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,654	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
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)	396,199	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	85.130855	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,786	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.548775	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,841,720		8,841,720	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,050,188		2,050,188	0	0	31.00
43.00	04300	NURSERY	521,088		521,088	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,428,174		2,428,174	0	0	50.00
51.00	05100	RECOVERY ROOM	581,335		581,335	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,005,860		3,005,860	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,438,581		3,438,581	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118,116		118,116	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,651,788	0	1,651,788	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,304,119	0	1,304,119	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,332	0	240,332	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	63,049	0	63,049	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	787,325		787,325	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,944		81,944	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,202		60,202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,069,500		4,069,500	0	0	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	428,894		428,894	0	0	90.00
91.00	09100	EMERGENCY	7,192,126		7,192,126	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,020,008		1,020,008		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,212,701		1,212,701	0	0	95.00
200.00		Subtotal (see instructions)	39,097,050	0	39,097,050	0	0	200.00
201.00		Less Observation Beds	1,020,008		1,020,008		0	201.00
202.00		Total (see instructions)	38,077,042	0	38,077,042	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,980,314		10,980,314			30.00
31.00	03100	INTENSIVE CARE UNIT	2,651,999		2,651,999			31.00
43.00	04300	NURSERY	215,567		215,567			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,201,352	10,768,404	13,969,756	0.173816	0.000000	50.00
51.00	05100	RECOVERY ROOM	558,934	2,422,942	2,981,876	0.194956	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,988,485	33,179,119	41,167,604	0.073015	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	8,994,958	18,889,705	27,884,663	0.123314	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	266,676	187,595	454,271	0.260012	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	6,001,862	833,669	6,835,531	0.241647	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,074,406	1,431,850	2,506,256	0.520345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	885,317	331,619	1,216,936	0.197489	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	70,068	81,911	151,979	0.414853	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,041,895	5,089,395	7,131,290	0.110404	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,420,596	1,799,675	4,220,271	0.019417	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,751	271,946	335,697	0.179334	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,457,452	14,163,153	34,620,605	0.117546	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,417	137,730	175,147	2.448766	0.000000	90.00
91.00	09100	EMERGENCY	4,234,920	26,519,931	30,754,851	0.233853	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	602,166	1,141,342	1,743,508	0.585032	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,037,752	11,037,752	0.109868	0.000000	95.00
200.00		Subtotal (see instructions)	72,748,135	128,287,738	201,035,873			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,748,135	128,287,738	201,035,873			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,841,720		8,841,720	0	8,841,720	30.00
31.00	03100	INTENSIVE CARE UNIT	2,050,188		2,050,188	0	2,050,188	31.00
43.00	04300	NURSERY	521,088		521,088	0	521,088	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,428,174		2,428,174	0	2,428,174	50.00
51.00	05100	RECOVERY ROOM	581,335		581,335	0	581,335	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,005,860		3,005,860	0	3,005,860	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,438,581		3,438,581	0	3,438,581	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118,116		118,116	0	118,116	62.00
65.00	06500	RESPIRATORY THERAPY	1,651,788	0	1,651,788	0	1,651,788	65.00
66.00	06600	PHYSICAL THERAPY	1,304,119	0	1,304,119	0	1,304,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,332	0	240,332	0	240,332	67.00
68.00	06800	SPEECH PATHOLOGY	63,049	0	63,049	0	63,049	68.00
69.00	06900	ELECTROCARDIOLOGY	787,325		787,325	0	787,325	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,944		81,944	0	81,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,202		60,202	0	60,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,069,500		4,069,500	0	4,069,500	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	428,894		428,894	0	428,894	90.00
91.00	09100	EMERGENCY	7,192,126		7,192,126	0	7,192,126	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,020,008		1,020,008		1,020,008	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,212,701		1,212,701	0	1,212,701	95.00
200.00		Subtotal (see instructions)	39,097,050	0	39,097,050	0	39,097,050	200.00
201.00		Less Observation Beds	1,020,008		1,020,008		1,020,008	201.00
202.00		Total (see instructions)	38,077,042	0	38,077,042	0	38,077,042	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,980,314		10,980,314			30.00
31.00	03100	INTENSIVE CARE UNIT	2,651,999		2,651,999			31.00
43.00	04300	NURSERY	215,567		215,567			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,201,352	10,768,404	13,969,756	0.173816	0.000000	50.00
51.00	05100	RECOVERY ROOM	558,934	2,422,942	2,981,876	0.194956	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,988,485	33,179,119	41,167,604	0.073015	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	8,994,958	18,889,705	27,884,663	0.123314	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	266,676	187,595	454,271	0.260012	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	6,001,862	833,669	6,835,531	0.241647	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,074,406	1,431,850	2,506,256	0.520345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	885,317	331,619	1,216,936	0.197489	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	70,068	81,911	151,979	0.414853	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,041,895	5,089,395	7,131,290	0.110404	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,420,596	1,799,675	4,220,271	0.019417	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,751	271,946	335,697	0.179334	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,457,452	14,163,153	34,620,605	0.117546	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,417	137,730	175,147	2.448766	0.000000	90.00
91.00	09100	EMERGENCY	4,234,920	26,519,931	30,754,851	0.233853	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	602,166	1,141,342	1,743,508	0.585032	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,037,752	11,037,752	0.109868	0.000000	95.00
200.00		Subtotal (see instructions)	72,748,135	128,287,738	201,035,873			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,748,135	128,287,738	201,035,873			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.173816	50.00
51.00	05100	RECOVERY ROOM	0.194956	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.073015	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.123314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.260012	62.00
65.00	06500	RESPIRATORY THERAPY	0.241647	65.00
66.00	06600	PHYSICAL THERAPY	0.520345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197489	67.00
68.00	06800	SPEECH PATHOLOGY	0.414853	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110404	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.019417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.179334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117546	73.00
76.00	03610	SLEEP LAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.448766	90.00
91.00	09100	EMERGENCY	0.233853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.585032	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.109868	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,428,174	581,126	1,847,048	0	0	50.00
51.00	05100	RECOVERY ROOM	581,335	53,469	527,866	0	0	51.00
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	3,005,860	517,799	2,488,061	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	3,438,581	242,910	3,195,671	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118,116	12,156	105,960	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,651,788	160,229	1,491,559	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,304,119	369,936	934,183	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,332	12,761	227,571	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	63,049	655	62,394	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	787,325	179,348	607,977	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,944	5,893	76,051	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,202	4,193	56,009	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,069,500	156,379	3,913,121	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	428,894	115,366	313,528	0	0	90.00
91.00	09100	EMERGENCY	7,192,126	416,840	6,775,286	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,020,008	167,131	852,877	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,212,701	144,492	1,068,209	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	27,684,054	3,140,683	24,543,371	0	0	200.00
201.00		Less Observation Beds	1,020,008	167,131	852,877	0	0	201.00
202.00		Total (line 200 minus line 201)	26,664,046	2,973,552	23,690,494	0	0	202.00

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

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,428,174	13,969,756	0.173816	50.00
51.00	05100	RECOVERY ROOM	581,335	2,981,876	0.194956	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,005,860	41,167,604	0.073015	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	3,438,581	27,884,663	0.123314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	118,116	454,271	0.260012	62.00
65.00	06500	RESPIRATORY THERAPY	1,651,788	6,835,531	0.241647	65.00
66.00	06600	PHYSICAL THERAPY	1,304,119	2,506,256	0.520345	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,332	1,216,936	0.197489	67.00
68.00	06800	SPEECH PATHOLOGY	63,049	151,979	0.414853	68.00
69.00	06900	ELECTROCARDIOLOGY	787,325	7,131,290	0.110404	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,944	4,220,271	0.019417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,202	335,697	0.179334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,069,500	34,620,605	0.117546	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	428,894	175,147	2.448766	90.00
91.00	09100	EMERGENCY	7,192,126	30,754,851	0.233853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,020,008	1,743,508	0.585032	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,212,701	11,037,752	0.109868	95.00
200.00		Subtotal (sum of lines 50 thru 199)	27,684,054	187,187,993		200.00
201.00		Less Observation Beds	1,020,008	0		201.00
202.00		Total (line 200 minus line 201)	26,664,046	187,187,993		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Hospital	Cost

		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	581,126	13,969,756	0.041599	602,374	25,058	50.00
51.00	05100	RECOVERY ROOM	53,469	2,981,876	0.017931	100,036	1,794	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	517,799	41,167,604	0.012578	2,791,219	35,108	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	242,910	27,884,663	0.008711	2,877,857	25,069	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,156	454,271	0.026759	140,545	3,761	62.00
65.00	06500	RESPIRATORY THERAPY	160,229	6,835,531	0.023441	1,855,044	43,484	65.00
66.00	06600	PHYSICAL THERAPY	369,936	2,506,256	0.147605	306,186	45,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,761	1,216,936	0.010486	258,516	2,711	67.00
68.00	06800	SPEECH PATHOLOGY	655	151,979	0.004310	30,427	131	68.00
69.00	06900	ELECTROCARDIOLOGY	179,348	7,131,290	0.025149	776,532	19,529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,893	4,220,271	0.001396	705,041	984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,193	335,697	0.012490	18,160	227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,379	34,620,605	0.004517	6,433,738	29,061	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	115,366	175,147	0.658681	0	0	90.00
91.00	09100	EMERGENCY	416,840	30,754,851	0.013554	39,286	532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	167,131	1,743,508	0.095859	14,552	1,395	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,996,191	176,150,241		16,949,513	234,039	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D Part IV

Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		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	13,969,756	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,981,876	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,167,604	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	27,884,663	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	454,271	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,835,531	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,506,256	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,216,936	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	151,979	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,131,290	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,220,271	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	335,697	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,620,605	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	175,147	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,754,851	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,743,508	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	176,150,241		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D Part IV

Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		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	602,374	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	100,036	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,791,219	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	2,877,857	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	140,545	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,855,044	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	306,186	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	258,516	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	30,427	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	776,532	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	705,041	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	18,160	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,433,738	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	39,286	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	14,552	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		16,949,513	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		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	0.173816	0	2,023,915	0	0	50.00
51.00	05100	RECOVERY ROOM	0.194956	0	498,375	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.073015	0	8,856,394	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.123314	0	4,294,119	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.260012	0	57,330	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.241647	0	192,972	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.520345	0	183,114	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197489	0	21,752	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.414853	0	8,134	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110404	0	1,624,918	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.019417	0	183,270	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.179334	0	60,171	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117546	0	5,064,908	496	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2.448766	0	12,528	48,029	0	90.00
91.00	09100	EMERGENCY	0.233853	0	6,212,531	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.585032	0	498,238	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.109868		0			95.00
200.00		Subtotal (see instructions)		0	29,792,669	48,525	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	29,792,669	48,525	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		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	351,789	0	50.00
51.00	05100	RECOVERY ROOM	97,161	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	646,650	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
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
60.00	06000	LABORATORY	529,525	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,906	0	62.00
65.00	06500	RESPIRATORY THERAPY	46,631	0	65.00
66.00	06600	PHYSICAL THERAPY	95,282	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,296	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	179,397	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,559	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,791	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	595,360	58	73.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	30,678	117,612	90.00
91.00	09100	EMERGENCY	1,452,819	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	291,485	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,353,703	117,670	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	4,353,703	117,670	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,448,741	278,552	1,170,189	4,285	273.09	30.00
31.00	INTENSIVE CARE UNIT	208,621		208,621	726	287.36	31.00
43.00	NURSERY	43,742		43,742	255	171.54	43.00
200.00	Total (lines 30 through 199)	1,701,104		1,422,552	5,266		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	91	24,851	30.00
31.00	INTENSIVE CARE UNIT	23	6,609	31.00
43.00	NURSERY	26	4,460	43.00
200.00	Total (lines 30 through 199)	140	35,920	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	581,126	13,969,756	0.041599	235,408	9,793	50.00
51.00	05100	RECOVERY ROOM	53,469	2,981,876	0.017931	34,003	610	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	517,799	41,167,604	0.012578	193,546	2,434	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	242,910	27,884,663	0.008711	228,736	1,993	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,156	454,271	0.026759	12,652	339	62.00
65.00	06500	RESPIRATORY THERAPY	160,229	6,835,531	0.023441	91,925	2,155	65.00
66.00	06600	PHYSICAL THERAPY	369,936	2,506,256	0.147605	9,638	1,423	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,761	1,216,936	0.010486	2,459	26	67.00
68.00	06800	SPEECH PATHOLOGY	655	151,979	0.004310	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	179,348	7,131,290	0.025149	15,647	394	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,893	4,220,271	0.001396	112,165	157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,193	335,697	0.012490	972	12	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	156,379	34,620,605	0.004517	538,868	2,434	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	115,366	175,147	0.658681	3,389	2,232	90.00
91.00	09100	EMERGENCY	416,840	30,754,851	0.013554	93,391	1,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	167,131	1,743,508	0.095859	15,342	1,471	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,996,191	176,150,241		1,588,141	26,739	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	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	4,285	0.00	91	30.00
31.00	03100	INTENSIVE CARE UNIT		0	726	0.00	23	31.00
43.00	04300	NURSERY		0	255	0.00	26	43.00
200.00		Total (lines 30 through 199)		0	5,266		140	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,969,756	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,981,876	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,167,604	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	27,884,663	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	454,271	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,835,531	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,506,256	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,216,936	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	151,979	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,131,290	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,220,271	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	335,697	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,620,605	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	175,147	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,754,851	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,743,508	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	176,150,241		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | 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	235,408	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	34,003	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	193,546	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	228,736	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	12,652	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	91,925	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	9,638	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,459	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,647	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	112,165	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	972	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	538,868	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	3,389	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	93,391	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	15,342	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,588,141	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | 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	0.173816	0	0	75,227	0	50.00
51.00	05100	RECOVERY ROOM	0.194956	0	0	16,328	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.073015	0	0	822,779	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.123314	0	0	576,130	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.260012	0	0	5,362	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.241647	0	0	17,931	0	65.00
66.00	06600	PHYSICAL THERAPY	0.520345	0	0	14,347	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197489	0	0	2,527	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.414853	0	0	1,715	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110404	0	0	87,477	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.019417	0	0	17,341	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.179334	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117546	0	0	345,248	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.448766	0	0	2,417	0	90.00
91.00	09100	EMERGENCY	0.233853	0	0	1,064,996	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.585032	0	0	52,294	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.109868	0	0			95.00
200.00		Subtotal (see instructions)		0	0	3,102,119	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	3,102,119	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | 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	13,076	50.00
51.00	05100	RECOVERY ROOM	0	3,183	51.00
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	60,075	54.00
54.01	05401	ULTRASOUND	0	0	54.01
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
60.00	06000	LABORATORY	0	71,045	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,394	62.00
65.00	06500	RESPIRATORY THERAPY	0	4,333	65.00
66.00	06600	PHYSICAL THERAPY	0	7,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	499	67.00
68.00	06800	SPEECH PATHOLOGY	0	711	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	40,583	73.00
76.00	03610	SLEEP LAB	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	5,919	90.00
91.00	09100	EMERGENCY	0	249,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	30,594	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	497,925	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	497,925	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,285	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)	3,673	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,020	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	235	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,545	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)	724	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	8,841,720	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)	1,700,014	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,141,706	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,141,706	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)	1,666.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,575,021	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,575,021	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,050,188	726	2,823.95	267	753,995	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)	2,267,333	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,596,349	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,206,676	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)	1,206,676	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)	612	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,666.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,020,008	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,448,741	8,841,720	0.163853	1,020,008	167,131	90.00
91.00	Nursing Program cost	0	8,841,720	0.000000	1,020,008	0	91.00
92.00	Allied health cost	0	8,841,720	0.000000	1,020,008	0	92.00
93.00	All other Medical Education	0	8,841,720	0.000000	1,020,008	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,540	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,285	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)	3,673	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,020	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	235	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)	91	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)	255	15.00
16.00	Nursery days (title V or XIX only)	26	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	8,841,720	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)	1,700,014	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,141,706	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,141,706	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)	1,666.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	151,668	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)	151,668	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/28/2022 9:17 am

Title XIX | 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)	521,088	255	2,043.48	26	53,130	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,050,188	726	2,823.95	23	64,951	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)	227,425	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	497,174	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)	35,920	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	26,739	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	62,659	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	434,515	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)	612	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,666.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,020,008	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/28/2022 9:17 am
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,448,741	8,841,720	0.163853	1,020,008	167,131	90.00
91.00	Nursing Program cost	0	8,841,720	0.000000	1,020,008	0	91.00
92.00	Allied health cost	0	8,841,720	0.000000	1,020,008	0	92.00
93.00	All other Medical Education	0	8,841,720	0.000000	1,020,008	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,576,030		30.00
31.00	03100	INTENSIVE CARE UNIT		939,648		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173816	602,374	104,702	50.00
51.00	05100	RECOVERY ROOM	0.194956	100,036	19,503	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.073015	2,791,219	203,801	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.123314	2,877,857	354,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.260012	140,545	36,543	62.00
65.00	06500	RESPIRATORY THERAPY	0.241647	1,855,044	448,266	65.00
66.00	06600	PHYSICAL THERAPY	0.520345	306,186	159,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197489	258,516	51,054	67.00
68.00	06800	SPEECH PATHOLOGY	0.414853	30,427	12,623	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110404	776,532	85,732	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.019417	705,041	13,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.179334	18,160	3,257	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117546	6,433,738	756,260	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.448766	0	0	90.00
91.00	09100	EMERGENCY	0.233853	39,286	9,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.585032	14,552	8,513	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,949,513	2,267,333	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)		16,949,513		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1318 | Component CCN: 15-Z318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173816	0	0	50.00
51.00	05100	RECOVERY ROOM	0.194956	2,435	475	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.073015	32,584	2,379	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.123314	283,051	34,904	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.260012	12,816	3,332	62.00
65.00	06500	RESPIRATORY THERAPY	0.241647	515,777	124,636	65.00
66.00	06600	PHYSICAL THERAPY	0.520345	243,922	126,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197489	220,945	43,634	67.00
68.00	06800	SPEECH PATHOLOGY	0.414853	18,981	7,874	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110404	6,160	680	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.019417	140,577	2,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.179334	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117546	906,161	106,516	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.448766	0	0	90.00
91.00	09100	EMERGENCY	0.233853	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.585032	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,383,409	454,084	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)		2,383,409		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/28/2022 9:17 am
	Title XIX	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		264,765		30.00
31.00	03100	INTENSIVE CARE UNIT		105,329		31.00
43.00	04300	NURSERY		24,330		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.173816	235,408	40,918	50.00
51.00	05100	RECOVERY ROOM	0.194956	34,003	6,629	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.073015	193,546	14,132	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.123314	228,736	28,206	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.260012	12,652	3,290	62.00
65.00	06500	RESPIRATORY THERAPY	0.241647	91,925	22,213	65.00
66.00	06600	PHYSICAL THERAPY	0.520345	9,638	5,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.197489	2,459	486	67.00
68.00	06800	SPEECH PATHOLOGY	0.414853	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110404	15,647	1,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.019417	112,165	2,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.179334	972	174	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117546	538,868	63,342	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.448766	3,389	8,299	90.00
91.00	09100	EMERGENCY	0.233853	93,391	21,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.585032	15,342	8,976	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,588,141	227,425	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)		1,588,141		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,471,373	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	5,968,178	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,471,373	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	4,516,087	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)	5,968,178	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	25,409	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,567,042	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)	-76,364	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)	-76,364	30.00
31.00	Primary payer payments	1,789	31.00
32.00	Subtotal (line 30 minus line 31)	-78,153	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)	625,988	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	406,892	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	534,704	36.00
37.00	Subtotal (see instructions)	328,739	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	328,739	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,373,937	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-1,045,198	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2022 9:17 am

Title XVIII | Hospital | Cost

		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		6,101,937		1,373,937	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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)		6,101,937		1,373,937	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		793,426		1,045,198	6.02
7.00	Total Medicare program liability (see instructions)		5,308,511		328,739	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: 15-1318 Component CCN: 15-Z318	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Swing Beds - SNF	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,807,670		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		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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)		1,807,670		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		144,586		0	6.02
7.00	Total Medicare program liability (see instructions)		1,663,084		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: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Hospital	Cost

		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 - SWING BEDS	Provider CCN: 15-1318 Component CCN: 15-Z318	Period: From 01/01/2021 To 12/31/2021	Worksheet E-2 Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,218,743	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	458,625	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	724	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,677,368	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,677,368	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,677,368	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,284	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,663,084	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,663,084	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,807,670	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-144,586	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/28/2022 9:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,596,349	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,596,349	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,652,312	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,652,312	19.00
20.00	Deductibles (exclude professional component)	404,752	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,247,560	22.00
23.00	Coinsurance	371	23.00
24.00	Subtotal (line 22 minus line 23)	5,247,189	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	94,341	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	61,322	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	54,567	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,308,511	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	5,308,511	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	6,101,937	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-793,426	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part VII Date/Time Prepared: 5/28/2022 9:17 am

		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			497,925	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	497,925	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	497,925	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		394,424		8.00
9.00	Ancillary service charges		1,588,141	3,102,119	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,982,565	3,102,119	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,982,565	3,102,119	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,982,565	2,604,194	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	497,925	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	497,925	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	497,925	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	497,925	36.00
37.00	REMOVE SETTLEMENT		0	-497,925	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/28/2022 9:17 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	-138,898	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,684,548	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,703,527	0	0	0	6.00
7.00	Inventory	888,998	0	0	0	7.00
8.00	Prepaid expenses	339,415	0	0	0	8.00
9.00	Other current assets	13,420	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,083,956	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	246,545	0	0	0	13.00
14.00	Accumulated depreciation	-149,655	0	0	0	14.00
15.00	Buildings	10,619,283	0	0	0	15.00
16.00	Accumulated depreciation	-4,477,644	0	0	0	16.00
17.00	Leasehold improvements	10,928,313	0	0	0	17.00
18.00	Accumulated depreciation	-5,271,933	0	0	0	18.00
19.00	Fixed equipment	3,112,251	0	0	0	19.00
20.00	Accumulated depreciation	-1,901,374	0	0	0	20.00
21.00	Automobiles and trucks	583,590	0	0	0	21.00
22.00	Accumulated depreciation	-583,590	0	0	0	22.00
23.00	Major movable equipment	6,394,101	0	0	0	23.00
24.00	Accumulated depreciation	-5,236,705	0	0	0	24.00
25.00	Minor equipment depreciable	4,327,142	0	0	0	25.00
26.00	Accumulated depreciation	-3,043,402	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,046,922	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,128,369	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,128,369	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,259,247	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,085,578	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,737,401	0	0	0	38.00
39.00	Payroll taxes payable	-8	0	0	0	39.00
40.00	Notes and loans payable (short term)	254,186	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-32,832,802	0	0	0	43.00
44.00	Other current liabilities	360,913	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-28,394,732	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	319,695	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	319,695	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-28,075,037	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	59,334,284				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)	59,334,284	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,259,247	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1318

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

Worksheet G-1

Date/Time Prepared:
5/28/2022 9:17 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		51,128,580		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,205,704				2.00
3.00	Total (sum of line 1 and line 2)		59,334,284		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)		59,334,284		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		59,334,284		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1318 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2022 9:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,195,881		11,195,881	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,195,881		11,195,881	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,651,999		2,651,999	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)	2,651,999		2,651,999	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,847,880		13,847,880	17.00
18.00	Ancillary services	54,025,752	89,450,983	143,476,735	18.00
19.00	Outpatient services	4,874,503	27,799,003	32,673,506	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	11,037,752	11,037,752	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,748,135	128,287,738	201,035,873	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,849,795		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)		40,849,795		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/28/2022 9:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	201,035,873	1.00
2.00	Less contractual allowances and discounts on patients' accounts	154,084,995	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,950,878	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,849,795	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,101,083	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	52,449	24.00
24.50	COVID-19 PHE Funding	2,052,172	24.50
25.00	Total other income (sum of lines 6-24)	2,104,621	25.00
26.00	Total (line 5 plus line 25)	8,205,704	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,205,704	29.00