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: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/31/2022 1:49 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2022 Time: 1:49 pm
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 FRANCISCAN HEALTH MOORESVILLE (15-0057) 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	1,383,514	-36,051	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1,383,514	-36,051	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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 1:49 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 HADLEY ROAD	PO Box:			1.00
2.00	City: MOORESVILLE	State: IN	Zip Code: 46158	County:	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	FRANCISCAN HEALTH MOORESVILLE	150057	26900	1	07/01/1996	N	P	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									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)	2		21.00

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

		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.	25	6	0	2	1,602	95	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.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	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	N		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 1:49 pm

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 1:49 pm

			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.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	N	N	N	N	109.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	287,134	57,250	124,047	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	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	158014	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 1:49 pm

	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: FRANCISCAN ALLIANCE, INC. AND AFFILI	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 1515 W DRAGOON TRL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46544	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)	9.99	169.00

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

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

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/06/2022	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/04/2022	Y	05/04/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 1:49 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	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.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	STEVE	HOWELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(765) 428-5927	STEVEN.HOWELL@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 1:49 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER COST REPORTING		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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 1:49 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	70	25,550	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		70	25,550	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	10	3,650	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		80	29,200	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		80				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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2022 1:49 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,236	33	5,971			1.00
2.00	HMO and other (see instructions)	2,298	1,601				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,236	33	5,971			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	156	0	1,521			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1	676			13.00
14.00	Total (see instructions)	2,392	34	8,168	0.00	302.09	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	302.09	27.00
28.00	Observation Bed Days		223	1,461			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	95	99			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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2022 1:49 pm

	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	745	51	2,238	1.00
2.00	HMO and other (see instructions)			513	579		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	745	51	2,238	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2022 1:49 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	23,190,401	0	23,190,401	328,898.66	70.51	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		739,990	0	739,990	22,030.05	33.59	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		572,805	0	572,805	5,254.25	109.02	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		88,636	0	88,636	594.06	149.20	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,348,064	0	8,348,064	245,523.00	34.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,660,300	0	7,660,300			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		252,942	0	252,942			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,543,194	0	2,543,194			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2022 1:49 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	606,596	0	606,596	17,866.09	33.95	27.00
28.00	Administrative & General under contract (see inst.)		443,360	0	443,360	4,105.65	107.99	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,240,948	0	1,240,948	43,756.29	28.36	30.00
31.00	Laundry & Linen Service	8.00	31,236	0	31,236	1,812.63	17.23	31.00
32.00	Housekeeping	9.00	1,247,095	0	1,247,095	69,636.16	17.91	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	322,092	-201,870	120,222	6,412.16	18.75	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	93,202	201,870	295,072	13,652.66	21.61	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	22,108	0	22,108	661.95	33.40	38.00
39.00	Central Services and Supply	14.00	141,279	0	141,279	6,786.64	20.82	39.00
40.00	Pharmacy	15.00	1,092,506	0	1,092,506	23,433.34	46.62	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Prepared: 5/31/2022 1:49 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		23,633,761	0	23,633,761	333,004.31	70.97	1.00
2.00	Excluded area salaries (see instructions)		739,990	0	739,990	22,030.05	33.59	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,893,771	0	22,893,771	310,974.26	73.62	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,009,505	0	9,009,505	251,371.31	35.84	4.00
5.00	Subtotal wage-related costs (see inst.)		10,203,494	0	10,203,494	0.00	44.57	5.00
6.00	Total (sum of lines 3 thru 5)		42,106,770	0	42,106,770	562,345.57	74.88	6.00
7.00	Total overhead cost (see instructions)		5,240,422	0	5,240,422	188,123.57	27.86	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2022 1:49 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	718,834	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)	1,342,824	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)	3,451,615	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	112,941	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	6,822	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)	151,521	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	369,592	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,751,271	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	707	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	7,115	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,913,242	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2022 1:49 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	7,913,242	1.00
2.00	Hospital	0	7,913,242	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/31/2022 1:49 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.163828	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,590,955	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	89,656,885	6.00
7.00	Medicaid cost (line 1 times line 6)	14,688,308	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)	0	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)	0	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)	5,753,316	2,096,651	7,849,967	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	942,554	2,096,651	3,039,205	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	942,554	2,096,651	3,039,205	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)	10,381,950	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	154,627	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	237,887	27.01
28.00	Non-Medicare bad debt expense (see instructions)	10,144,063	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,745,142	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,784,347	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,784,347	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/31/2022 1:49 pm

		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		0	0	2,252,293	2,252,293	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,723,565	1,723,565	-292,689	1,430,876	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	7,894,229	7,894,229	4.00
5.01	00570	ADMITTING	0	0	0	0	0	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	606,596	5,573,690	6,180,286	-456,450	5,723,836	5.03
7.00	00700	OPERATION OF PLANT	1,240,948	2,571,261	3,812,209	-680,442	3,131,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,236	-33,026	-1,790	-21,569	-23,359	8.00
9.00	00900	HOUSEKEEPING	1,247,095	1,010,358	2,257,453	-877,431	1,380,022	9.00
10.00	01000	DIETARY	322,092	339,456	661,548	-628,477	33,071	10.00
11.00	01100	CAFETERIA	93,202	144,941	238,143	326,562	564,705	11.00
13.00	01300	NURSING ADMINISTRATION	22,108	33,466	55,574	-28,360	27,214	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	141,279	258,244	399,523	8,833,435	9,232,958	14.00
15.00	01500	PHARMACY	1,092,506	2,781,017	3,873,523	-2,760,692	1,112,831	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,916,041	4,420,397	9,336,438	-3,990,242	5,346,196	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,074,446	928,199	3,002,645	-708,296	2,294,349	34.00
43.00	04300	NURSERY	0	0	0	464,242	464,242	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,781,009	13,386,435	15,167,444	-11,717,268	3,450,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,933	1,725	7,658	1,580,247	1,587,905	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,987,613	1,328,256	3,315,869	-1,176,934	2,138,935	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	471,901	4,785,305	5,257,206	-583,961	4,673,245	55.00
60.00	06000	LABORATORY	0	3,730,673	3,730,673	-327,586	3,403,087	60.00
64.00	06400	INTRAVENOUS THERAPY	219,179	14,316,578	14,535,757	-13,973,515	562,242	64.00
65.00	06500	RESPIRATORY THERAPY	1,070,721	526,089	1,596,810	-503,355	1,093,455	65.00
66.00	06600	PHYSICAL THERAPY	1,541,636	518,527	2,060,163	-507,777	1,552,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,396	78,266	285,662	-75,672	209,990	67.00
68.00	06800	SPEECH PATHOLOGY	26,230	25,946	52,176	-25,170	27,006	68.00
69.00	06900	ELECTROCARDIOLOGY	59,038	23,284	82,322	-23,203	59,119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,509	64,943	72,452	-48,805	23,647	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,358,449	3,358,449	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	16,065,158	16,065,158	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	24,261	24,261	-23,767	494	90.00
90.01	09001	WOUND CARE INSTITUTE	3,172	2,808	5,980	-2,710	3,270	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	35,535	16,157	51,692	-16,157	35,535	90.02
91.00	09100	EMERGENCY	3,245,990	1,610,575	4,856,565	-1,285,508	3,571,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-224,674	-224,674	224,674	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,450,411	59,966,722	82,417,133	263,253	82,680,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,108	68,823	102,931	-24,286	78,645	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	451,459	289,207	740,666	-161,561	579,105	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	254,423	275,075	529,498	-76,375	453,123	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	15,937,153	15,937,153	-1,031	15,936,122	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	23,190,401	76,536,980	99,727,381	0	99,727,381	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	861,893	3,114,186	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,430,876	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,605,071	11,499,300	4.00
5.01	00570	ADMITTING	-148	-148	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	16,423,020	22,146,856	5.03
7.00	00700	OPERATION OF PLANT	1,038,919	4,170,686	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-18,993	-42,352	8.00
9.00	00900	HOUSEKEEPING	-21,900	1,358,122	9.00
10.00	01000	DIETARY	-750,645	-717,574	10.00
11.00	01100	CAFETERIA	-200,359	364,346	11.00
13.00	01300	NURSING ADMINISTRATION	65,950	93,164	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8,415	9,224,543	14.00
15.00	01500	PHARMACY	94,857	1,207,688	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,680	29,680	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,018,786	3,327,410	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-240	2,294,109	34.00
43.00	04300	NURSERY	0	464,242	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,520,770	1,929,406	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,587,905	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	206,217	2,345,152	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	59,416	4,732,661	55.00
60.00	06000	LABORATORY	149,007	3,552,094	60.00
64.00	06400	INTRAVENOUS THERAPY	61,798	624,040	64.00
65.00	06500	RESPIRATORY THERAPY	-1,721	1,091,734	65.00
66.00	06600	PHYSICAL THERAPY	-2,761	1,549,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,990	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,006	68.00
69.00	06900	ELECTROCARDIOLOGY	0	59,119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,647	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,358,449	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,065,158	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	494	90.00
90.01	09001	WOUND CARE INSTITUTE	0	3,270	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	35,535	90.02
91.00	09100	EMERGENCY	-240	3,570,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,050,850	100,731,236	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	78,645	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	579,105	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	15	15	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	453,123	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	194.03
194.04	07954	OTHER NRCC	4,262,580	20,198,702	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	22,313,445	122,040,826	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,358,449	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,972,175	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	12,330,624	
	B - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,065,158	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	16,065,158	
	C - EQUIPMENT LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	77,656	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	77,656	
	D - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,252,293	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	2,252,293	

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	E - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,894,229	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	0		0	7,894,229	
	F - CAFETERIA				
1.00	CAFETERIA	11.00	201,870	201,997	1.00
	0		201,870	201,997	
	G - NURSERY				
1.00	NURSERY	43.00	416,482	47,760	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,419,178	162,745	2.00
	0		1,835,660	210,505	
	H - CAPITALIZED INTEREST				
1.00	INTEREST EXPENSE	113.00	0	224,674	1.00
	TOTALS		0	224,674	
500.00	Grand Total: Increases		2,037,530	39,257,136	500.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/31/2022 1:49 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - MEDICAL SUPPLIES					
1.00	OTHER ADMIN & GENERAL	5.03	0	207,362	9	1.00
2.00	OPERATION OF PLANT	7.00	0	267	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	2	0	3.00
4.00	HOUSEKEEPING	9.00	0	12,671	0	4.00
5.00	DIETARY	10.00	0	8,799	0	5.00
6.00	CAFETERIA	11.00	0	17,454	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	2,088	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	60,937	0	8.00
9.00	PHARMACY	15.00	0	57,760	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	276,806	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	120,568	0	11.00
12.00	OPERATING ROOM	50.00	0	10,521,735	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	273	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	181,128	0	14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	910	0	15.00
16.00	LABORATORY	60.00	0	228,596	0	16.00
17.00	INTRAVENOUS THERAPY	64.00	0	118,397	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	155,527	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	8,102	0	19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	9,138	0	20.00
21.00	SPEECH PATHOLOGY	68.00	0	964	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	8,817	0	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,165	0	23.00
24.00	WOUND CARE INSTITUTE	90.01	0	1,666	0	24.00
25.00	EMERGENCY	91.00	0	320,492	0	25.00
	0		0	12,330,624		
	B - DRUGS					
1.00	PHARMACY	15.00	0	2,394,303	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,462	0	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	328	0	3.00
4.00	OPERATING ROOM	50.00	0	10,567	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,439	0	6.00
7.00	INTRAVENOUS THERAPY	64.00	0	13,615,520	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	1,673	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	219	0	9.00
10.00	WOUND CARE INSTITUTE	90.01	0	2	0	10.00
11.00	EMERGENCY	91.00	0	17,473	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,130	0	12.00
13.00	OTHER NRCC	194.04	0	1,031	0	13.00
	0		0	16,065,158		
	C - EQUIPMENT LEASE					
1.00	HOUSEKEEPING	9.00	0	570	10	1.00
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	71,265	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	5,821	0	3.00
	0		0	77,656		
	D - DEPRECIATION					
1.00	OTHER ADMIN & GENERAL	5.03	0	4,764	9	1.00
2.00	OPERATION OF PLANT	7.00	0	102,795	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,069	0	3.00
4.00	HOUSEKEEPING	9.00	0	18,706	0	4.00
5.00	DIETARY	10.00	0	19,909	0	5.00
6.00	CAFETERIA	11.00	0	3,566	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	10,788	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	851	0	8.00
9.00	PHARMACY	15.00	0	30,601	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	141,554	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	36,491	0	11.00
12.00	OPERATING ROOM	50.00	0	574,199	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	394,113	0	13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	426,174	0	14.00
15.00	LABORATORY	60.00	0	98,990	0	15.00
16.00	INTRAVENOUS THERAPY	64.00	0	49,069	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	26,446	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	54,262	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	799	0	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	35,698	0	20.00
21.00	CLINIC	90.00	0	23,767	0	21.00
22.00	OP NUTRITIONAL COUNSELING	90.02	0	347	0	22.00
23.00	EMERGENCY	91.00	0	51,664	0	23.00
24.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	145,671	9	24.00
	0		0	2,252,293		

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	E - EMPLOYEE BENEFITS					
1.00	OTHER ADMIN & GENERAL	5.03	0	244,324	0	1.00
2.00	OPERATION OF PLANT	7.00	0	577,380	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	20,498	0	3.00
4.00	HOUSEKEEPING	9.00	0	845,484	0	4.00
5.00	DIETARY	10.00	0	195,902	0	5.00
6.00	CAFETERIA	11.00	0	56,285	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	15,484	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	76,952	0	8.00
9.00	PHARMACY	15.00	0	278,028	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,522,255	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	479,644	0	11.00
12.00	OPERATING ROOM	50.00	0	610,767	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,392	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	596,254	0	14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	156,877	0	15.00
16.00	INTRAVENOUS THERAPY	64.00	0	190,529	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	313,888	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	445,194	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	65,735	0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	24,206	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	14,386	0	21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,942	0	22.00
23.00	WOUND CARE INSTITUTE	90.01	0	1,042	0	23.00
24.00	OP NUTRITIONAL COUNSELING	90.02	0	15,810	0	24.00
25.00	EMERGENCY	91.00	0	895,879	0	25.00
26.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	24,286	0	26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	146,431	0	27.00
28.00	PLAINFIELD RADIOLOGY & PHYSICAL THE	194.01	0	76,375	0	28.00
	0		0	7,894,229		
	F - CAFETERIA					
1.00	DIETARY	10.00	201,870	201,997	0	1.00
	0		201,870	201,997		
	G - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	1,835,660	210,505	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,835,660	210,505		
	H - CAPITALIZED INTEREST					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	224,674	11	1.00
	TOTALS		0	224,674		
500.00	Grand Total: Decreases		2,037,530	39,257,136		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2022 1:49 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,639,290	120,980	0	120,980	0	2.00
3.00	Buildings and Fixtures	63,285,635	40,906	0	40,906	532,168	3.00
4.00	Building Improvements	2,719,750	245,270	0	245,270	0	4.00
5.00	Fixed Equipment	46,364,059	0	0	0	338,239	5.00
6.00	Movable Equipment	29,461,179	1,273,882	0	1,273,882	2,753,036	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,469,913	1,681,038	0	1,681,038	3,623,443	8.00
9.00	Reconciling Items	0	-18,203,972	0	-18,203,972	0	9.00
10.00	Total (line 8 minus line 9)	144,469,913	19,885,010	0	19,885,010	3,623,443	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	2,760,270	1,317,559	2.00
3.00	Buildings and Fixtures	62,794,373	2,961,410	3.00
4.00	Building Improvements	2,965,020	507,373	4.00
5.00	Fixed Equipment	46,025,820	0	5.00
6.00	Movable Equipment	27,982,025	15,560,127	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,527,508	20,346,469	8.00
9.00	Reconciling Items	-18,203,972	0	9.00
10.00	Total (line 8 minus line 9)	160,731,480	20,346,469	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2022 1:49 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,723,565	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,723,565	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	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,723,565	2.00
3.00	Total (sum of lines 1-2)	0	1,723,565	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2022 1:49 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	114,545,483	0	114,545,483	0.820519	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,406,567	1,350,785	25,055,782	0.179481	0	2.00
3.00	Total (sum of lines 1-2)	140,952,050	1,350,785	139,601,265	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	2,252,293	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,577,894	77,656	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,830,187	77,656	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	861,893	0	0	0	3,114,186	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-224,674	0	0	0	1,430,876	2.00
3.00	Total (sum of lines 1-2)	637,219	0	0	0	4,545,062	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/31/2022 1:49 pm

	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)	B	61,798	INTRAVENOUS THERAPY	64.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-17,792	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,717,621			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	30,176,662			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-121,105	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,837	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	CAFETERIA-EMPLOYEES AND GUESTS	B	-16	ADULTS & PEDIATRICS	30.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/31/2022 1:49 pm

	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	CAFETERIA-EMPLOYEES AND GUESTS	B	-5	OPERATING ROOM	50.00	0	33.01
33.02	CAFETERIA-EMPLOYEES AND GUESTS	B	-3	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	MISC INCOME	B	-25,066	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MISC INCOME	B	-75,842	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-18,993	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	MISC INCOME	B	-21,265	HOUSEKEEPING	9.00	0	33.06
33.07	MISC INCOME	B	-745,372	DIETARY	10.00	0	33.07
33.08	MISC INCOME	B	-74,632	CAFETERIA	11.00	0	33.08
33.09	MISC INCOME	B	-47,375	PHARMACY	15.00	0	33.09
33.10	MISC INCOME	B	-314	ADULTS & PEDIATRICS	30.00	0	33.10
33.11	MISC INCOME	B	-240	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.11
33.12	MISC INCOME	B	-12,598	OPERATING ROOM	50.00	0	33.12
33.13	MISC INCOME	B	-63,342	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	MISC INCOME	B	59,450	RADIOLOGY-THERAPEUTIC	55.00	0	33.14
33.15	MISC INCOME	B	-1,721	RESPIRATORY THERAPY	65.00	0	33.15
33.16	MISC INCOME	B	-2,570	PHYSICAL THERAPY	66.00	0	33.16
33.17	MISC INCOME	B	-240	EMERGENCY	91.00	0	33.17
33.18	VENDING MACHINES	B	-556	DIETARY	10.00	0	33.18
33.19	NEUROLOGY TESTING EXPENSES	A	0	ELECTROENCEPHALOGRAPHY	70.00	0	33.19
33.20	ON CALL COVERAGE	A	0	OTHER ADMIN & GENERAL	5.03	0	33.20
33.21	ON CALL COVERAGE	A	0	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	NON ALLOWABLE INTEREST	A	-271,003	CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	HAF OFFSET	A	-4,148,383	OTHER ADMIN & GENERAL	5.03	0	33.23
33.24	PENSION ADJ PER REGS 2142.5	A	1,420,782	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	ADVERTISING	A	-777	OTHER ADMIN & GENERAL	5.03	0	33.25
33.26	DUES AND SUBSCRIPTIONS	A	-7,559	OPERATION OF PLANT	7.00	0	33.26
33.27	MISC EXPENSE	A	-310	OTHER ADMIN & GENERAL	5.03	0	33.27
33.28	MISC EXPENSE	A	-296	OPERATION OF PLANT	7.00	0	33.28
33.29	MISC EXPENSE	A	-635	HOUSEKEEPING	9.00	0	33.29
33.30	MISC EXPENSE	A	-4,010	NURSING ADMINISTRATION	13.00	0	33.30
33.31	MISC EXPENSE	A	147	RADIOLOGY-DIAGNOSTIC	54.00	0	33.31
33.32	MISC EXPENSE	A	-191	PHYSICAL THERAPY	66.00	0	33.32
34.00	OTHER HOSP LOCATION	A	-186	OPERATION OF PLANT	7.00	0	34.00
34.01	OTHER HOSP LOCATION	A	-4,717	DIETARY	10.00	0	34.01
34.02	OTHER HOSP LOCATION	A	-1,785	CAFETERIA	11.00	0	34.02
34.03	OTHER HOSP LOCATION	A	-96	ADULTS & PEDIATRICS	30.00	0	34.03
34.04	OTHER HOSP LOCATION	A	-34	RADIOLOGY-THERAPEUTIC	55.00	0	34.04
34.05	OTHER HOSP LOCATION	A	-203	LABORATORY	60.00	0	34.05
35.00	NON-HOSP LOCATION	B	-148	ADMITTING	5.01	0	35.00
35.01	NON-HOSP LOCATION	A	-7,154	OTHER ADMIN & GENERAL	5.03	0	35.01
35.02	NON-HOSP LOCATION	A	-8,415	CENTRAL SERVICES & SUPPLY	14.00	0	35.02
35.03	NON-HOSP LOCATION	A	13	LABORATORY	60.00	0	35.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		22,313,445				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: 15-0057

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

Worksheet A-8-1

Date/Time Prepared: 5/31/2022 1:49 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	2,184,289	0	1.00
2.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	4,498,818	0	2.00
3.00	7.00	OPERATION OF PLANT	SHARED SERVICE ALLOCAITON	1,140,594	0	3.00
4.00	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	69,960	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	29,680	0	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	SHARED SERVICE ALLOCATION	269,415	0	4.02
4.04	194.00	COMMUNITY RELATIONS & MARKET	SHARED SERVICE ALLOCATION	15	0	4.04
4.05	194.04	OTHER NRCC	SHARED SERVICE ALLOCATION	4,262,580	0	4.05
4.06	60.00	LABORATORY	SHARED SERVICE ALLOCATION	3,539,767	3,390,570	4.06
4.07	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	14,828,937	0	4.07
4.08	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	1,132,896	0	4.08
4.09	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	1,036,658	0	4.09
4.10	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	431,391	0	4.10
4.11	15.00	PHARMACY	FRANCISCAN HOME OFFICE	142,232	0	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			33,567,232	3,390,570	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.

6.00	B	HOME OFFICE	100.00	FRANC. ALLIANCE	100.00	6.00
7.00	B	APHL	100.00	APHL	100.00	7.00
8.00	G	FH CENTRAL INDY	100.00	FRANC. HEALTH	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:	REGION HOME OFF				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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2022 1:49 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	2,184,289	0	1.00
2.00	4,498,818	0	2.00
3.00	1,140,594	0	3.00
4.00	69,960	0	4.00
4.01	29,680	0	4.01
4.02	269,415	0	4.02
4.04	15	0	4.04
4.05	4,262,580	0	4.05
4.06	149,197	0	4.06
4.07	14,828,937	0	4.07
4.08	1,132,896	11	4.08
4.09	1,036,658	0	4.09
4.10	431,391	0	4.10
4.11	142,232	0	4.11
5.00	30,176,662		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.

	Type of Business	
6.00	HEALTH SYSTEM	6.00
7.00	SHARED LAB	7.00
8.00	HOSPITAL	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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2022 1:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMIN & GENERAL	191,094	191,094	0	179,000	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,018,360	2,018,360	0	179,000	0	2.00
3.00	50.00	OPERATING ROOM	1,508,167	1,508,167	0	246,400	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			3,717,621	3,717,621	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	5.03	OTHER ADMIN & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	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	5.03	OTHER ADMIN & GENERAL	0	0	0	191,094	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,018,360	2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,508,167	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	3,717,621	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/31/2022 1:49 pm

		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	3,114,186	3,114,186				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,430,876		1,430,876			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,499,300	0	0	11,499,300		4.00
5.01	00570	ADMITTING	-148	27,230	12,511	0	39,593	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	22,146,856	76,771	35,274	300,790	0	5.03
7.00	00700	OPERATION OF PLANT	4,170,686	652,192	299,663	615,343	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-42,352	10,058	4,621	15,489	0	8.00
9.00	00900	HOUSEKEEPING	1,358,122	49,598	22,789	618,391	0	9.00
10.00	01000	DIETARY	-717,574	38,328	17,610	59,614	0	10.00
11.00	01100	CAFETERIA	364,346	32,912	15,122	146,316	0	11.00
13.00	01300	NURSING ADMINISTRATION	93,164	1,224	562	10,963	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,224,543	21,791	10,012	70,055	0	14.00
15.00	01500	PHARMACY	1,207,688	23,015	10,575	541,735	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,680	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,327,410	412,861	189,698	1,527,453	4,601	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,294,109	91,413	42,002	1,028,645	1,972	34.00
43.00	04300	NURSERY	464,242	0	0	206,519	562	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,929,406	254,551	116,959	883,140	6,194	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,587,905	0	0	706,663	1,978	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,345,152	95,201	43,742	985,588	1,776	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,732,661	79,646	36,595	233,999	95	55.00
60.00	06000	LABORATORY	3,552,094	44,841	20,603	0	3,466	60.00
64.00	06400	INTRAVENOUS THERAPY	624,040	0	0	108,683	187	64.00
65.00	06500	RESPIRATORY THERAPY	1,091,734	25,856	11,880	530,933	1,362	65.00
66.00	06600	PHYSICAL THERAPY	1,549,625	80,166	36,834	764,443	771	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,990	47,104	21,643	102,840	85	67.00
68.00	06800	SPEECH PATHOLOGY	27,006	0	0	13,007	102	68.00
69.00	06900	ELECTROCARDIOLOGY	59,119	11,028	5,067	29,275	360	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,647	36,064	16,570	3,723	21	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,358,449	0	0	0	3,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,065,158	0	0	0	3,497	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	11	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	494	31,214	14,342	0	8	90.00
90.01	09001	WOUND CARE INSTITUTE	3,270	0	0	1,573	2	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	35,535	0	0	17,621	0	90.02
91.00	09100	EMERGENCY	3,570,817	148,599	68,277	1,609,564	3,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,731,236	2,291,663	1,052,951	11,132,365	39,593	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,645	12,726	5,847	16,913	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	579,105	0	0	223,863	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	15	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	453,123	0	0	126,159	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	20,198,702	809,797	372,078	0	0	194.04
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)	122,040,826	3,114,186	1,430,876	11,499,300	39,593	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE	0					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	22,559,691	22,559,691			5.03
7.00	00700	OPERATION OF PLANT	0	5,737,884	1,293,216	7,031,100		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-12,184	0	29,992	17,808	8.00
9.00	00900	HOUSEKEEPING	0	2,048,900	461,785	147,893	0	9.00
10.00	01000	DIETARY	0	-602,022	0	114,286	0	10.00
11.00	01100	CAFETERIA	0	558,696	125,920	98,136	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	105,913	23,871	3,650	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,326,401	2,102,003	64,977	0	14.00
15.00	01500	PHARMACY	0	1,783,013	401,859	68,626	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,680	6,689	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,462,023	1,231,042	1,231,076	5,377	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	3,458,141	779,403	272,578	1,466	34.00
43.00	04300	NURSERY	0	671,323	151,304	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,190,250	719,025	759,024	3,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,296,546	517,600	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,471,459	782,404	283,872	2,173	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,082,996	1,145,616	237,490	0	55.00
60.00	06000	LABORATORY	0	3,621,004	816,109	133,706	19	60.00
64.00	06400	INTRAVENOUS THERAPY	0	732,910	165,185	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,661,765	374,532	77,097	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,431,839	548,093	239,039	447	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	381,662	86,020	140,455	119	67.00
68.00	06800	SPEECH PATHOLOGY	0	40,115	9,041	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	104,849	23,631	32,884	17	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	80,025	18,036	107,537	17	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,362,083	757,753	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,351	1,206	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,068,655	3,621,586	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	11	2	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	46,058	10,381	93,074	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	4,845	1,092	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	53,156	11,980	0	0	90.02
91.00	09100	EMERGENCY	0	5,400,815	1,217,246	443,094	4,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	99,163,853	17,403,630	4,578,486	17,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	114,131	25,723	37,946	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	802,968	180,975	0	30	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	15	3	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	579,282	130,560	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	21,380,577	4,818,800	2,414,668	519	194.04
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)	0	122,040,826	22,559,691	7,031,100	17,808	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,658,578					9.00
10.00	01000	DIETARY	44,335	-443,401				10.00
11.00	01100	CAFETERIA	38,070	0	820,822			11.00
13.00	01300	NURSING ADMINISTRATION	1,416	0	1,228	136,078		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,206	0	0	14	11,518,601	14.00
15.00	01500	PHARMACY	26,622	0	43,466	0	10,694	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	477,573	0	223,961	55,094	17,009	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	105,741	0	76,154	20,477	6,834	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	294,449	0	85,614	16,994	79,173	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	338	14	11	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,123	0	96,889	7	4,751	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	92,130	0	22,701	1,308	1,278	55.00
60.00	06000	LABORATORY	51,869	0	0	0	234	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	551	7,780	64.00
65.00	06500	RESPIRATORY THERAPY	29,908	0	44,478	0	1,158	65.00
66.00	06600	PHYSICAL THERAPY	92,731	0	74,308	0	4,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,487	0	9,855	0	1,554	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,248	0	345	68.00
69.00	06900	ELECTROCARDIOLOGY	12,757	0	2,161	0	74	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,717	0	367	0	615	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,149,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,216,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36,107	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	54	91	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	171,890	0	134,261	40,210	11,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,707,131	0	817,029	134,723	11,514,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,720	0	3,793	0	214	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,355	1,745	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	1,112	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	936,727	0	0	0	1,493	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	-443,401	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,658,578	-443,401	820,822	136,078	11,518,601	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	2,334,280					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,369				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,314	0	0	8,704,469	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	388	0	0	4,721,182	34.00
43.00	04300	NURSERY	0	111	0	0	822,738	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,681	0	0	5,150,665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	390	0	0	2,814,899	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,681	0	0	4,756,359	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,332	0	0	6,585,851	55.00
60.00	06000	LABORATORY	0	3,287	0	0	4,626,228	60.00
64.00	06400	INTRAVENOUS THERAPY	0	688	0	0	907,114	64.00
65.00	06500	RESPIRATORY THERAPY	0	503	0	0	2,189,441	65.00
66.00	06600	PHYSICAL THERAPY	0	897	0	0	3,391,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	141	0	0	674,293	67.00
68.00	06800	SPEECH PATHOLOGY	0	41	0	0	50,790	68.00
69.00	06900	ELECTROCARDIOLOGY	0	104	0	0	176,477	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	144	0	0	248,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,556	0	0	7,270,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,486	0	0	8,225,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,334,280	8,014	0	0	22,032,535	73.00
74.00	07400	RENAL DIALYSIS	0	2	0	0	15	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	9	0	0	185,629	90.00
90.01	09001	WOUND CARE INSTITUTE	0	1	0	0	6,083	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	4	0	0	65,140	90.02
91.00	09100	EMERGENCY	0	6,595	0	0	7,430,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,334,280	36,369	0	0	91,036,871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	196,527	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	987,073	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	18	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	710,954	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	0	29,552,784	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	-443,401	201.00
202.00		TOTAL (sum lines 118 through 201)	2,334,280	36,369	0	0	122,040,826	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	8,704,469	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	4,721,182	34.00
43.00	04300	NURSERY	0	822,738	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	5,150,665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,814,899	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,756,359	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,585,851	55.00
60.00	06000	LABORATORY	0	4,626,228	60.00
64.00	06400	INTRAVENOUS THERAPY	0	907,114	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,189,441	65.00
66.00	06600	PHYSICAL THERAPY	0	3,391,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	674,293	67.00
68.00	06800	SPEECH PATHOLOGY	0	50,790	68.00
69.00	06900	ELECTROCARDIOLOGY	0	176,477	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	248,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,270,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,225,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,032,535	73.00
74.00	07400	RENAL DIALYSIS	0	15	74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	185,629	90.00
90.01	09001	WOUND CARE INSTITUTE	0	6,083	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	65,140	90.02
91.00	09100	EMERGENCY	0	7,430,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	91,036,871	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	196,527	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	987,073	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	18	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	710,954	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	194.03
194.04	07954	OTHER NRCC	0	29,552,784	194.04
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	-443,401	201.00
202.00		TOTAL (sum lines 118 through 201)	0	122,040,826	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 1:49 pm

		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	0	0	0	0	4.00
5.01	00570	ADMITTING	0	27,230	12,511	39,741	0	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	76,771	35,274	112,045	0	5.03
7.00	00700	OPERATION OF PLANT	0	652,192	299,663	951,855	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,058	4,621	14,679	0	8.00
9.00	00900	HOUSEKEEPING	0	49,598	22,789	72,387	0	9.00
10.00	01000	DIETARY	0	38,328	17,610	55,938	0	10.00
11.00	01100	CAFETERIA	0	32,912	15,122	48,034	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,224	562	1,786	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,791	10,012	31,803	0	14.00
15.00	01500	PHARMACY	0	23,015	10,575	33,590	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	412,861	189,698	602,559	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	91,413	42,002	133,415	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	254,551	116,959	371,510	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,201	43,742	138,943	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	79,646	36,595	116,241	0	55.00
60.00	06000	LABORATORY	0	44,841	20,603	65,444	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	25,856	11,880	37,736	0	65.00
66.00	06600	PHYSICAL THERAPY	0	80,166	36,834	117,000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	47,104	21,643	68,747	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,028	5,067	16,095	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	36,064	16,570	52,634	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	31,214	14,342	45,556	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	148,599	68,277	216,876	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,291,663	1,052,951	3,344,614	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,726	5,847	18,573	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	809,797	372,078	1,181,875	0	194.04
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	3,114,186	1,430,876	4,545,062	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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	39,593					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	112,045			5.03
7.00	00700	OPERATION OF PLANT	0	0	6,421	958,276		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,088	5,555	8.00
9.00	00900	HOUSEKEEPING	0	0	2,293	20,156	0	9.00
10.00	01000	DIETARY	0	0	0	15,576	0	10.00
11.00	01100	CAFETERIA	0	0	625	13,375	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	119	497	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	10,436	8,856	0	14.00
15.00	01500	PHARMACY	0	0	1,995	9,353	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	33	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,601	0	6,112	167,785	1,678	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,972	0	3,870	37,150	457	34.00
43.00	04300	NURSERY	562	0	751	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,194	0	3,570	103,448	1,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,978	0	2,570	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,776	0	3,885	38,689	678	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	95	0	5,688	32,368	0	55.00
60.00	06000	LABORATORY	3,466	0	4,052	18,223	6	60.00
64.00	06400	INTRAVENOUS THERAPY	187	0	820	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,362	0	1,860	10,508	0	65.00
66.00	06600	PHYSICAL THERAPY	771	0	2,721	32,579	139	66.00
67.00	06700	OCCUPATIONAL THERAPY	85	0	427	19,143	37	67.00
68.00	06800	SPEECH PATHOLOGY	102	0	45	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	360	0	117	4,482	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21	0	90	14,656	5	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,634	0	3,762	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,351	0	6	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,497	0	17,981	0	0	73.00
74.00	07400	RENAL DIALYSIS	11	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8	0	52	12,685	0	90.00
90.01	09001	WOUND CARE INSTITUTE	2	0	5	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	59	0	0	90.02
91.00	09100	EMERGENCY	3,558	0	6,044	60,390	1,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,593	0	86,409	624,007	5,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	128	5,172	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	899	0	10	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	648	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	23,961	329,097	162	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	148	0	0	0	13,212	201.00
202.00		TOTAL (sum lines 118 through 201)	39,741	0	112,045	958,276	18,767	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	94,836					9.00
10.00	01000	DIETARY	1,582	73,096				10.00
11.00	01100	CAFETERIA	1,358	0	63,392			11.00
13.00	01300	NURSING ADMINISTRATION	51	0	95	2,548		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	899	0	0	0	51,994	14.00
15.00	01500	PHARMACY	950	0	3,357	0	48	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,036	0	17,297	1,034	77	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,772	0	5,881	383	31	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,504	0	6,612	318	357	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	26	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,928	0	7,483	0	21	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,286	0	1,753	24	6	55.00
60.00	06000	LABORATORY	1,850	0	0	0	1	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10	35	64.00
65.00	06500	RESPIRATORY THERAPY	1,067	0	3,435	0	5	65.00
66.00	06600	PHYSICAL THERAPY	3,308	0	5,739	0	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,944	0	761	0	7	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	96	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	455	0	167	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,488	0	28	0	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	37,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,288	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	1	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,132	0	10,369	753	54	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,898	0	63,099	2,523	51,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	525	0	293	0	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	25	8	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	5	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	33,413	0	0	0	7	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	73,096	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,836	73,096	63,392	2,548	51,994	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0057

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

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	
					SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			15.00	16.00	21.00	22.00	24.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	49,293					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0			818,179	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0			186,931	34.00
43.00	04300	NURSERY	0	0			1,313	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0			503,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			4,574	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			195,403	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			159,461	55.00
60.00	06000	LABORATORY	0	0			93,042	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0			1,052	64.00
65.00	06500	RESPIRATORY THERAPY	0	0			55,973	65.00
66.00	06600	PHYSICAL THERAPY	0	0			162,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			91,151	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			245	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			21,681	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			68,925	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			21,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			42,445	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,293	33			70,804	73.00
74.00	07400	RENAL DIALYSIS	0	0			11	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0			59,589	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0			8	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0			59	90.02
91.00	09100	EMERGENCY	0	0			305,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,293	33	0	0	2,863,804	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			24,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0			942	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0			0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0			653	194.01
194.02	07952	JV MV ENDOSCOPY	0	0			0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0			0	194.03
194.04	07954	OTHER NRCC	0	0			1,568,515	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	86,456	201.00
202.00		TOTAL (sum lines 118 through 201)	49,293	33	0	0	4,545,062	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMIN & GENERAL			5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	818,179	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	186,931	34.00
43.00	04300	NURSERY	0	1,313	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	503,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,574	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	195,403	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	159,461	55.00
60.00	06000	LABORATORY	0	93,042	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,052	64.00
65.00	06500	RESPIRATORY THERAPY	0	55,973	65.00
66.00	06600	PHYSICAL THERAPY	0	162,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	91,151	67.00
68.00	06800	SPEECH PATHOLOGY	0	245	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,681	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	68,925	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,445	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,804	73.00
74.00	07400	RENAL DIALYSIS	0	11	74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	59,589	90.00
90.01	09001	WOUND CARE INSTITUTE	0	8	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	59	90.02
91.00	09100	EMERGENCY	0	305,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,863,804	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	942	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	653	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	194.03
194.04	07954	OTHER NRCC	0	1,568,515	194.04
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	86,456	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,545,062	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	269,675					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		269,675				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	23,190,401			4.00
5.01	00570	ADMITTING	2,358	2,358	0	119,986,898		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	555,685,193	5.02
5.03	00590	OTHER ADMIN & GENERAL	6,648	6,648	606,596	0	0	5.03
7.00	00700	OPERATION OF PLANT	56,477	56,477	1,240,948	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	871	871	31,236	0	0	8.00
9.00	00900	HOUSEKEEPING	4,295	4,295	1,247,095	0	0	9.00
10.00	01000	DIETARY	3,319	3,319	120,222	0	0	10.00
11.00	01100	CAFETERIA	2,850	2,850	295,072	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	106	106	22,108	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,887	1,887	141,279	0	0	14.00
15.00	01500	PHARMACY	1,993	1,993	1,092,506	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,752	35,752	3,080,381	13,942,302	20,214,817	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,916	7,916	2,074,446	5,975,172	5,975,172	34.00
43.00	04300	NURSERY	0	0	416,482	1,702,124	1,702,124	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,043	22,043	1,781,009	18,784,893	41,246,091	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,425,111	5,993,621	5,993,621	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,244	8,244	1,987,613	5,380,670	72,015,238	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,897	6,897	471,901	287,303	35,872,973	55.00
60.00	06000	LABORATORY	3,883	3,883	0	10,502,288	50,562,194	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	219,179	567,269	10,581,063	64.00
65.00	06500	RESPIRATORY THERAPY	2,239	2,239	1,070,721	4,126,750	7,733,962	65.00
66.00	06600	PHYSICAL THERAPY	6,942	6,942	1,541,636	2,336,707	13,799,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,079	4,079	207,396	258,777	2,175,838	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	26,230	307,890	625,878	68.00
69.00	06900	ELECTROCARDIOLOGY	955	955	59,038	1,091,526	1,595,811	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,123	3,123	7,509	63,416	2,212,193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,011,860	23,944,671	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,214,522	38,243,222	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,596,327	119,487,787	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	31,926	31,926	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,703	2,703	0	23,563	136,890	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	3,172	6,001	10,751	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	35,535	0	62,282	90.02
91.00	09100	EMERGENCY	12,868	12,868	3,245,990	10,781,991	101,461,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	198,448	198,448	22,450,411	119,986,898	555,685,193	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,102	1,102	34,108	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	451,459	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	254,423	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	70,125	70,125	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,114,186	1,430,876	11,499,300	39,593	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.547922	5.305928	0.495865	0.000330	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	39,741	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000330	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-22,559,691	100,095,341				5.03
7.00	00700	OPERATION OF PLANT	0	5,737,884	204,192			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,184	0	871	355,247		8.00
9.00	00900	HOUSEKEEPING	0	2,048,900	4,295	0	199,026	9.00
10.00	01000	DIETARY	602,022	0	3,319	0	3,319	10.00
11.00	01100	CAFETERIA	0	558,696	2,850	0	2,850	11.00
13.00	01300	NURSING ADMINISTRATION	0	105,913	106	0	106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,326,401	1,887	0	1,887	14.00
15.00	01500	PHARMACY	0	1,783,013	1,993	0	1,993	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,680	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,462,023	35,752	107,261	35,752	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	3,458,141	7,916	29,245	7,916	34.00
43.00	04300	NURSERY	0	671,323	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,190,250	22,043	68,924	22,043	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,296,546	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,471,459	8,244	43,340	8,244	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,082,996	6,897	0	6,897	55.00
60.00	06000	LABORATORY	0	3,621,004	3,883	384	3,883	60.00
64.00	06400	INTRAVENOUS THERAPY	0	732,910	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,661,765	2,239	0	2,239	65.00
66.00	06600	PHYSICAL THERAPY	0	2,431,839	6,942	8,914	6,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	381,662	4,079	2,370	4,079	67.00
68.00	06800	SPEECH PATHOLOGY	0	40,115	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	104,849	955	345	955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	80,025	3,123	338	3,123	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,362,083	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,351	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,068,655	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	11	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	46,058	2,703	0	2,703	90.00
90.01	09001	WOUND CARE INSTITUTE	0	4,845	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	53,156	0	0	0	90.02
91.00	09100	EMERGENCY	0	5,400,815	12,868	83,166	12,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,945,485	77,218,368	132,965	344,287	127,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	114,131	1,102	0	1,102	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	802,968	0	608	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	15	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	579,282	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	21,380,577	70,125	10,352	70,125	194.04
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)		22,559,691	7,031,100	17,808	2,658,578	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.225382	34.433768	0.050129	13.357943	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		112,045	958,276	18,767	94,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001119	4.693014	0.015637	0.476501	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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NUR SING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	8,168					10.00
11.00	01100	CAFETERIA	0	442,500				11.00
13.00	01300	NURSING ADMINISTRATION	0	662	225,381			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	24	12,577,970		14.00
15.00	01500	PHARMACY	0	23,432	0	11,677	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,971	120,736	91,247	18,573	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,521	41,054	33,915	7,463	0	34.00
43.00	04300	NURSERY	676	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,154	28,146	86,455	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	182	24	12	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,232	12	5,188	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,238	2,167	1,395	0	55.00
60.00	06000	LABORATORY	0	0	0	256	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	913	8,495	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	23,978	0	1,265	0	65.00
66.00	06600	PHYSICAL THERAPY	0	40,059	0	5,011	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,313	0	1,697	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	673	0	377	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,165	0	81	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	198	0	672	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,439,032	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,972,175	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	90	99	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	72,379	66,598	13,064	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,168	440,455	223,136	12,572,987	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,045	0	234	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,245	1,905	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	1,214	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	1,630	0	194.04
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)	-443,401	820,822	136,078	11,518,601	2,334,280	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1.854965	0.603769	0.915776	23,342.800000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,096	63,392	2,548	51,994	49,293	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.949070	0.143259	0.011305	0.004134	492.930000	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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/31/2022 1:49 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			16.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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	555,685,193			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	20,214,817	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,975,172	0	0	34.00
43.00	04300	NURSERY	1,702,124	0	0	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	41,246,091	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,993,621	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,015,238	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,872,973	0	0	55.00
60.00	06000	LABORATORY	50,562,194	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	10,581,063	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,733,962	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,799,040	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,175,838	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	625,878	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,595,811	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,212,193	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,944,671	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,243,222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,487,787	0	0	73.00
74.00	07400	RENAL DIALYSIS	31,926	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	136,890	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	10,751	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	62,282	0	0	90.02
91.00	09100	EMERGENCY	101,461,649	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	555,685,193	0	0	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	194.04
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)	36,369	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000065	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/31/2022 1:49 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total 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	8,704,469		8,704,469	0	8,704,469	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,721,182		4,721,182	0	4,721,182	34.00
43.00	04300	NURSERY	822,738		822,738	0	822,738	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,150,665		5,150,665	0	5,150,665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,814,899		2,814,899	0	2,814,899	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,756,359		4,756,359	0	4,756,359	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,585,851		6,585,851	0	6,585,851	55.00
60.00	06000	LABORATORY	4,626,228		4,626,228	0	4,626,228	60.00
64.00	06400	INTRAVENOUS THERAPY	907,114		907,114	0	907,114	64.00
65.00	06500	RESPIRATORY THERAPY	2,189,441	0	2,189,441	0	2,189,441	65.00
66.00	06600	PHYSICAL THERAPY	3,391,943	0	3,391,943	0	3,391,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	674,293	0	674,293	0	674,293	67.00
68.00	06800	SPEECH PATHOLOGY	50,790	0	50,790	0	50,790	68.00
69.00	06900	ELECTROCARDIOLOGY	176,477		176,477	0	176,477	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248,458		248,458	0	248,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,270,775		7,270,775	0	7,270,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,225,543		8,225,543	0	8,225,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,032,535		22,032,535	0	22,032,535	73.00
74.00	07400	RENAL DIALYSIS	15		15	0	15	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	185,629		185,629	0	185,629	90.00
90.01	09001	WOUND CARE INSTITUTE	6,083		6,083	0	6,083	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	65,140		65,140	0	65,140	90.02
91.00	09100	EMERGENCY	7,430,244		7,430,244	0	7,430,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,711,138		1,711,138		1,711,138	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,748,009	0	92,748,009	0	92,748,009	200.00
201.00		Less Observation Beds	1,711,138		1,711,138		1,711,138	201.00
202.00		Total (see instructions)	91,036,871	0	91,036,871	0	91,036,871	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 1:49 pm

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		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	12,976,490		12,976,490			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,975,172		5,975,172			34.00
43.00	04300	NURSERY	1,702,124		1,702,124			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,784,893	22,461,198	41,246,091	0.124876	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,993,621	0	5,993,621	0.469649	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,380,670	66,634,568	72,015,238	0.066047	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	287,303	35,585,670	35,872,973	0.183588	0.000000	55.00
60.00	06000	LABORATORY	10,502,288	40,059,906	50,562,194	0.091496	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	567,269	10,013,794	10,581,063	0.085730	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,126,750	3,607,212	7,733,962	0.283094	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,336,707	11,462,333	13,799,040	0.245810	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,777	1,917,061	2,175,838	0.309900	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	307,890	317,988	625,878	0.081150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,091,526	504,285	1,595,811	0.110588	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	63,416	2,148,777	2,212,193	0.112313	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,011,860	12,932,811	23,944,671	0.303649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,214,522	22,028,700	38,243,222	0.215085	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,596,327	108,891,460	119,487,787	0.184392	0.000000	73.00
74.00	07400	RENAL DIALYSIS	31,926	0	31,926	0.000470	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,563	113,327	136,890	1.356045	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	6,001	4,750	10,751	0.565808	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	62,282	62,282	1.045888	0.000000	90.02
91.00	09100	EMERGENCY	10,781,991	90,679,658	101,461,649	0.073232	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	965,812	6,272,515	7,238,327	0.236400	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,986,898	435,698,295	555,685,193			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	119,986,898	435,698,295	555,685,193			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/31/2022 1:49 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.124876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.469649	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066047	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183588	55.00
60.00	06000	LABORATORY	0.091496	60.00
64.00	06400	INTRAVENOUS THERAPY	0.085730	64.00
65.00	06500	RESPIRATORY THERAPY	0.283094	65.00
66.00	06600	PHYSICAL THERAPY	0.245810	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.309900	67.00
68.00	06800	SPEECH PATHOLOGY	0.081150	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112313	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184392	73.00
74.00	07400	RENAL DIALYSIS	0.000470	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.356045	90.00
90.01	09001	WOUND CARE INSTITUTE	0.565808	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.045888	90.02
91.00	09100	EMERGENCY	0.073232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.236400	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 1:49 pm

Title XIX | Hospital | PPS

		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	8,704,469		8,704,469	0	8,704,469	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,721,182		4,721,182	0	4,721,182	34.00
43.00	04300	NURSERY	822,738		822,738	0	822,738	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,150,665		5,150,665	0	5,150,665	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,814,899		2,814,899	0	2,814,899	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,756,359		4,756,359	0	4,756,359	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,585,851		6,585,851	0	6,585,851	55.00
60.00	06000	LABORATORY	4,626,228		4,626,228	0	4,626,228	60.00
64.00	06400	INTRAVENOUS THERAPY	907,114		907,114	0	907,114	64.00
65.00	06500	RESPIRATORY THERAPY	2,189,441	0	2,189,441	0	2,189,441	65.00
66.00	06600	PHYSICAL THERAPY	3,391,943	0	3,391,943	0	3,391,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	674,293	0	674,293	0	674,293	67.00
68.00	06800	SPEECH PATHOLOGY	50,790	0	50,790	0	50,790	68.00
69.00	06900	ELECTROCARDIOLOGY	176,477		176,477	0	176,477	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248,458		248,458	0	248,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,270,775		7,270,775	0	7,270,775	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,225,543		8,225,543	0	8,225,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,032,535		22,032,535	0	22,032,535	73.00
74.00	07400	RENAL DIALYSIS	15		15	0	15	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	185,629		185,629	0	185,629	90.00
90.01	09001	WOUND CARE INSTITUTE	6,083		6,083	0	6,083	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	65,140		65,140	0	65,140	90.02
91.00	09100	EMERGENCY	7,430,244		7,430,244	0	7,430,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,711,138		1,711,138		1,711,138	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,748,009	0	92,748,009	0	92,748,009	200.00
201.00		Less Observation Beds	1,711,138		1,711,138		1,711,138	201.00
202.00		Total (see instructions)	91,036,871	0	91,036,871	0	91,036,871	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/31/2022 1:49 pm

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		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	12,976,490		12,976,490			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,975,172		5,975,172			34.00
43.00	04300	NURSERY	1,702,124		1,702,124			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,784,893	22,461,198	41,246,091	0.124876	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,993,621	0	5,993,621	0.469649	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,380,670	66,634,568	72,015,238	0.066047	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	287,303	35,585,670	35,872,973	0.183588	0.000000	55.00
60.00	06000	LABORATORY	10,502,288	40,059,906	50,562,194	0.091496	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	567,269	10,013,794	10,581,063	0.085730	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,126,750	3,607,212	7,733,962	0.283094	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,336,707	11,462,333	13,799,040	0.245810	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,777	1,917,061	2,175,838	0.309900	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	307,890	317,988	625,878	0.081150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,091,526	504,285	1,595,811	0.110588	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	63,416	2,148,777	2,212,193	0.112313	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,011,860	12,932,811	23,944,671	0.303649	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,214,522	22,028,700	38,243,222	0.215085	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,596,327	108,891,460	119,487,787	0.184392	0.000000	73.00
74.00	07400	RENAL DIALYSIS	31,926	0	31,926	0.000470	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,563	113,327	136,890	1.356045	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	6,001	4,750	10,751	0.565808	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	62,282	62,282	1.045888	0.000000	90.02
91.00	09100	EMERGENCY	10,781,991	90,679,658	101,461,649	0.073232	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	965,812	6,272,515	7,238,327	0.236400	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,986,898	435,698,295	555,685,193			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	119,986,898	435,698,295	555,685,193			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I | Date/Time Prepared: 5/31/2022 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.124876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.469649	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066047	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183588	55.00
60.00	06000	LABORATORY	0.091496	60.00
64.00	06400	INTRAVENOUS THERAPY	0.085730	64.00
65.00	06500	RESPIRATORY THERAPY	0.283094	65.00
66.00	06600	PHYSICAL THERAPY	0.245810	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.309900	67.00
68.00	06800	SPEECH PATHOLOGY	0.081150	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112313	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184392	73.00
74.00	07400	RENAL DIALYSIS	0.000470	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.356045	90.00
90.01	09001	WOUND CARE INSTITUTE	0.565808	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.045888	90.02
91.00	09100	EMERGENCY	0.073232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.236400	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/31/2022 1:49 pm

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	5,150,665	503,591	4,647,074	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,814,899	4,574	2,810,325	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,756,359	195,403	4,560,956	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,585,851	159,461	6,426,390	0	0	55.00
60.00	06000	LABORATORY	4,626,228	93,042	4,533,186	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	907,114	1,052	906,062	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,189,441	55,973	2,133,468	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,391,943	162,278	3,229,665	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	674,293	91,151	583,142	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,790	245	50,545	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	176,477	21,681	154,796	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248,458	68,925	179,533	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,270,775	21,613	7,249,162	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,225,543	42,445	8,183,098	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,032,535	70,804	21,961,731	0	0	73.00
74.00	07400	RENAL DIALYSIS	15	11	4	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	185,629	59,589	126,040	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	6,083	8	6,075	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	65,140	59	65,081	0	0	90.02
91.00	09100	EMERGENCY	7,430,244	305,476	7,124,768	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,711,138	160,838	1,550,300	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	78,499,620	2,018,219	76,481,401	0	0	200.00
201.00		Less Observation Beds	1,711,138	160,838	1,550,300	0	0	201.00
202.00		Total (line 200 minus line 201)	76,788,482	1,857,381	74,931,101	0	0	202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II | Date/Time Prepared: 5/31/2022 1:49 pm

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	5,150,665	41,246,091	0.124876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,814,899	5,993,621	0.469649	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,756,359	72,015,238	0.066047	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,585,851	35,872,973	0.183588	55.00
60.00	06000	LABORATORY	4,626,228	50,562,194	0.091496	60.00
64.00	06400	INTRAVENOUS THERAPY	907,114	10,581,063	0.085730	64.00
65.00	06500	RESPIRATORY THERAPY	2,189,441	7,733,962	0.283094	65.00
66.00	06600	PHYSICAL THERAPY	3,391,943	13,799,040	0.245810	66.00
67.00	06700	OCCUPATIONAL THERAPY	674,293	2,175,838	0.309900	67.00
68.00	06800	SPEECH PATHOLOGY	50,790	625,878	0.081150	68.00
69.00	06900	ELECTROCARDIOLOGY	176,477	1,595,811	0.110588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248,458	2,212,193	0.112313	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,270,775	23,944,671	0.303649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,225,543	38,243,222	0.215085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,032,535	119,487,787	0.184392	73.00
74.00	07400	RENAL DIALYSIS	15	31,926	0.000470	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	185,629	136,890	1.356045	90.00
90.01	09001	WOUND CARE INSTITUTE	6,083	10,751	0.565808	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	65,140	62,282	1.045888	90.02
91.00	09100	EMERGENCY	7,430,244	101,461,649	0.073232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,711,138	7,238,327	0.236400	92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	78,499,620	535,031,407		200.00
201.00		Less Observation Beds	1,711,138	0		201.00
202.00		Total (line 200 minus line 201)	76,788,482	535,031,407		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	818,179	0	818,179	7,432	110.09	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	186,931		186,931	1,521	122.90	34.00
43.00	NURSERY	1,313		1,313	676	1.94	43.00
200.00	Total (lines 30 through 199)	1,006,423		1,006,423	9,629		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,236	246,161	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	156	19,172	34.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,392	265,333	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	503,591	41,246,091	0.012209	7,231,174	88,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,574	5,993,621	0.000763	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,403	72,015,238	0.002713	1,990,025	5,399	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	159,461	35,872,973	0.004445	79,888	355	55.00
60.00	06000	LABORATORY	93,042	50,562,194	0.001840	2,990,415	5,502	60.00
64.00	06400	INTRAVENOUS THERAPY	1,052	10,581,063	0.000099	197,451	20	64.00
65.00	06500	RESPIRATORY THERAPY	55,973	7,733,962	0.007237	1,178,061	8,526	65.00
66.00	06600	PHYSICAL THERAPY	162,278	13,799,040	0.011760	1,082,483	12,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,151	2,175,838	0.041892	98,068	4,108	67.00
68.00	06800	SPEECH PATHOLOGY	245	625,878	0.000391	44,205	17	68.00
69.00	06900	ELECTROCARDIOLOGY	21,681	1,595,811	0.013586	359,064	4,878	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	68,925	2,212,193	0.031157	17,307	539	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,613	23,944,671	0.000903	4,633,798	4,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,445	38,243,222	0.001110	7,507,105	8,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,804	119,487,787	0.000593	3,066,115	1,818	73.00
74.00	07400	RENAL DIALYSIS	11	31,926	0.000345	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	59,589	136,890	0.435306	338	147	90.00
90.01	09001	WOUND CARE INSTITUTE	8	10,751	0.000744	995	1	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	59	62,282	0.000947	0	0	90.02
91.00	09100	EMERGENCY	305,476	101,461,649	0.003011	4,110,385	12,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	160,838	7,238,327	0.022220	439,023	9,755	92.00
200.00		Total (lines 50 through 199)	2,018,219	535,031,407		35,025,900	166,973	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	7,432	0.00	2,236	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,521	0.00	156	34.00
43.00	04300	NURSERY		0	676	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,629		2,392	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
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: 15-0057

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

Worksheet D Part IV
Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-0057

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

Worksheet D Part IV

Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	41,246,091	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,993,621	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	72,015,238	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	35,872,973	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	50,562,194	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,581,063	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,733,962	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,799,040	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,175,838	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	625,878	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,595,811	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,212,193	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,944,671	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,243,222	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	119,487,787	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	31,926	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	136,890	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	10,751	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	62,282	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	101,461,649	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,238,327	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	535,031,407		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	7,231,174	0	4,930,647	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,990,025	0	15,428,670	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	79,888	0	12,383,900	0	55.00
60.00	06000	LABORATORY	0.000000	2,990,415	0	823,138	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	197,451	0	4,095,248	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,178,061	0	936,840	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,082,483	0	251,359	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	98,068	0	20,763	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	44,205	0	719	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	359,064	0	127,298	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	17,307	0	390,812	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,633,798	0	3,288,283	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,507,105	0	5,456,621	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,066,115	0	42,127,406	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	338	0	3,699	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	995	0	1,929	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	4,110,385	0	14,645,238	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	439,023	0	518,781	0	92.00
200.00		Total (lines 50 through 199)		35,025,900	0	105,431,351	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.124876	4,930,647	0	0	615,719	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.469649	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066047	15,428,670	0	0	1,019,017	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183588	12,383,900	0	0	2,273,535	55.00
60.00	06000	LABORATORY	0.091496	823,138	0	0	75,314	60.00
64.00	06400	INTRAVENOUS THERAPY	0.085730	4,095,248	0	0	351,086	64.00
65.00	06500	RESPIRATORY THERAPY	0.283094	936,840	0	0	265,214	65.00
66.00	06600	PHYSICAL THERAPY	0.245810	251,359	0	0	61,787	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.309900	20,763	0	0	6,434	67.00
68.00	06800	SPEECH PATHOLOGY	0.081150	719	0	0	58	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110588	127,298	0	0	14,078	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112313	390,812	0	0	43,893	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303649	3,288,283	0	0	998,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215085	5,456,621	0	0	1,173,637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184392	42,127,406	0	0	7,767,957	73.00
74.00	07400	RENAL DIALYSIS	0.000470	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.356045	3,699	0	0	5,016	90.00
90.01	09001	WOUND CARE INSTITUTE	0.565808	1,929	0	0	1,091	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.045888	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.073232	14,645,238	0	0	1,072,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.236400	518,781	0	0	122,640	92.00
200.00		Subtotal (see instructions)		105,431,351	0	0	15,867,460	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		105,431,351	0	0	15,867,460	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/31/2022 1:49 pm

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	818,179	0	818,179	7,432	110.09	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	186,931		186,931	1,521	122.90	34.00
43.00	NURSERY	1,313		1,313	676	1.94	43.00
200.00	Total (lines 30 through 199)	1,006,423		1,006,423	9,629		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	33	3,633	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
43.00	NURSERY	1	2	43.00
200.00	Total (lines 30 through 199)	34	3,635	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/31/2022 1:49 pm

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	503,591	41,246,091	0.012209	1,742,369	21,273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,574	5,993,621	0.000763	2,784,646	2,125	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,403	72,015,238	0.002713	567,493	1,540	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	159,461	35,872,973	0.004445	0	0	55.00
60.00	06000	LABORATORY	93,042	50,562,194	0.001840	1,652,669	3,041	60.00
64.00	06400	INTRAVENOUS THERAPY	1,052	10,581,063	0.000099	83,607	8	64.00
65.00	06500	RESPIRATORY THERAPY	55,973	7,733,962	0.007237	542,148	3,924	65.00
66.00	06600	PHYSICAL THERAPY	162,278	13,799,040	0.011760	109,562	1,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,151	2,175,838	0.041892	18,795	787	67.00
68.00	06800	SPEECH PATHOLOGY	245	625,878	0.000391	119,112	47	68.00
69.00	06900	ELECTROCARDIOLOGY	21,681	1,595,811	0.013586	111,261	1,512	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	68,925	2,212,193	0.031157	1,798	56	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,613	23,944,671	0.000903	993,219	897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,445	38,243,222	0.001110	783,120	869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,804	119,487,787	0.000593	1,347,149	799	73.00
74.00	07400	RENAL DIALYSIS	11	31,926	0.000345	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	59,589	136,890	0.435306	12,076	5,257	90.00
90.01	09001	WOUND CARE INSTITUTE	8	10,751	0.000744	181	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	59	62,282	0.000947	0	0	90.02
91.00	09100	EMERGENCY	305,476	101,461,649	0.003011	1,269,907	3,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	160,838	7,238,327	0.022220	54,466	1,210	92.00
200.00		Total (lines 50 through 199)	2,018,219	535,031,407		12,193,578	48,457	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/31/2022 1:49 pm

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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
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	7,432	0.00	33	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,521	0.00	0	34.00
43.00	04300	NURSERY		0	676	0.00	1	43.00
200.00		Total (lines 30 through 199)		0	9,629		34	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
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: 15-0057

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

Worksheet D Part IV Date/Time Prepared: 5/31/2022 1:49 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/31/2022 1:49 pm

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	41,246,091	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,993,621	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	72,015,238	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	35,872,973	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	50,562,194	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,581,063	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,733,962	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,799,040	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,175,838	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	625,878	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,595,811	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,212,193	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,944,671	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,243,222	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	119,487,787	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	31,926	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	136,890	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	10,751	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	62,282	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	101,461,649	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,238,327	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	535,031,407		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/31/2022 1:49 pm

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	1,742,369	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,784,646	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	567,493	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	1,652,669	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	83,607	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	542,148	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	109,562	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,795	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	119,112	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	111,261	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,798	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	993,219	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	783,120	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,347,149	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	12,076	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	181	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	1,269,907	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	54,466	0	0	0	92.00
200.00		Total (lines 50 through 199)		12,193,578	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/31/2022 1:49 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.124876	0	0	2,337,790	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.469649	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066047	0	0	11,726,612	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183588	0	0	344,012	0	55.00
60.00	06000	LABORATORY	0.091496	0	0	7,938,901	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.085730	0	0	753,683	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.283094	0	0	522,901	0	65.00
66.00	06600	PHYSICAL THERAPY	0.245810	0	0	1,480,983	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.309900	0	0	233,406	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.081150	0	0	30,077	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110588	0	0	64,251	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112313	0	0	580,068	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303649	0	0	1,701,296	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215085	0	0	1,692,681	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184392	0	0	9,678,795	0	73.00
74.00	07400	RENAL DIALYSIS	0.000470	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.356045	0	0	57,279	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.565808	0	0	1,050	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.045888	0	0	14,550	0	90.02
91.00	09100	EMERGENCY	0.073232	0	0	31,339,879	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.236400	0	0	1,266,182	0	92.00
200.00		Subtotal (see instructions)		0	0	71,764,396	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	71,764,396	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V | Date/Time Prepared: 5/31/2022 1:49 pm

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	291,934	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	774,508	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	63,156	55.00
60.00	06000	LABORATORY	0	726,378	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64,613	64.00
65.00	06500	RESPIRATORY THERAPY	0	148,030	65.00
66.00	06600	PHYSICAL THERAPY	0	364,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72,333	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,441	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,105	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	65,149	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	516,597	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	364,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,784,692	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	77,673	90.00
90.01	09001	WOUND CARE INSTITUTE	0	594	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	15,218	90.02
91.00	09100	EMERGENCY	0	2,295,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	299,325	92.00
200.00		Subtotal (see instructions)	0	7,932,938	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	7,932,938	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/31/2022 1:49 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,432	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)	5,971	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,236	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,704,469	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,704,469	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)	8,704,469	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)	1,171.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,618,826	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)	2,618,826	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	4,721,182	1,521	3,104.00	156	484,224	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)	6,007,755	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,110,805	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)	265,333	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	166,973	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	432,306	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,678,499	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,461	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,171.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,711,138	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	818,179	8,704,469	0.093995	1,711,138	160,838	90.00
91.00	Nursing Program cost	0	8,704,469	0.000000	1,711,138	0	91.00
92.00	Allied health cost	0	8,704,469	0.000000	1,711,138	0	92.00
93.00	All other Medical Education	0	8,704,469	0.000000	1,711,138	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 1:49 pm

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)	7,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,432	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)	5,971	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	33	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)	676	15.00
16.00	Nursery days (title V or XIX only)	1	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,704,469	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,704,469	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)	8,704,469	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)	1,171.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	38,650	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)	38,650	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/31/2022 1:49 pm

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)	822,738	676	1,217.07	1	1,217	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	4,721,182	1,521	3,104.00	0	0	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)	2,770,437	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,810,304	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)	3,635	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	48,457	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	52,092	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,758,212	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,461	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,171.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,711,138	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 Date/Time Prepared: 5/31/2022 1:49 pm

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	818,179	8,704,469	0.093995	1,711,138	160,838	90.00
91.00	Nursing Program cost	0	8,704,469	0.000000	1,711,138	0	91.00
92.00	Allied health cost	0	8,704,469	0.000000	1,711,138	0	92.00
93.00	All other Medical Education	0	8,704,469	0.000000	1,711,138	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,670,599		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,401,413		34.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.124876	7,231,174	903,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.469649	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066047	1,990,025	131,435	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183588	79,888	14,666	55.00
60.00	06000	LABORATORY	0.091496	2,990,415	273,611	60.00
64.00	06400	INTRAVENOUS THERAPY	0.085730	197,451	16,927	64.00
65.00	06500	RESPIRATORY THERAPY	0.283094	1,178,061	333,502	65.00
66.00	06600	PHYSICAL THERAPY	0.245810	1,082,483	266,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.309900	98,068	30,391	67.00
68.00	06800	SPEECH PATHOLOGY	0.081150	44,205	3,587	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110588	359,064	39,708	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112313	17,307	1,944	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303649	4,633,798	1,407,048	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215085	7,507,105	1,614,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184392	3,066,115	565,367	73.00
74.00	07400	RENAL DIALYSIS	0.000470	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.356045	338	458	90.00
90.01	09001	WOUND CARE INSTITUTE	0.565808	995	563	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.045888	0	0	90.02
91.00	09100	EMERGENCY	0.073232	4,110,385	301,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.236400	439,023	103,785	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,025,900	6,007,755	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)		35,025,900		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/31/2022 1:49 pm

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		1,637,504		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		939,787		34.00
43.00	04300	NURSERY		1,066,945		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.124876	1,742,369	217,580	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.469649	2,784,646	1,307,806	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.066047	567,493	37,481	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.183588	0	0	55.00
60.00	06000	LABORATORY	0.091496	1,652,669	151,213	60.00
64.00	06400	INTRAVENOUS THERAPY	0.085730	83,607	7,168	64.00
65.00	06500	RESPIRATORY THERAPY	0.283094	542,148	153,479	65.00
66.00	06600	PHYSICAL THERAPY	0.245810	109,562	26,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.309900	18,795	5,825	67.00
68.00	06800	SPEECH PATHOLOGY	0.081150	119,112	9,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110588	111,261	12,304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112313	1,798	202	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303649	993,219	301,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.215085	783,120	168,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184392	1,347,149	248,403	73.00
74.00	07400	RENAL DIALYSIS	0.000470	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.356045	12,076	16,376	90.00
90.01	09001	WOUND CARE INSTITUTE	0.565808	181	102	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.045888	0	0	90.02
91.00	09100	EMERGENCY	0.073232	1,269,907	92,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.236400	54,466	12,876	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,193,578	2,770,437	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)		12,193,578		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,745,716	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,999,746	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	63,879	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	5,779,811	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	76.00	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.34	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.93	31.00
32.00	Sum of lines 30 and 31	24.27	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.24	33.00
34.00	Disproportionate share adjustment (see instructions)	178,920	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/31/2022 1:49 pm

	Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000305200	0.000266342	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,530,113	1,915,533	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,892,385	482,820	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,375,205		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,363,466		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,363,466	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	595,340	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	31,381	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,990,187	59.00
60.00	Primary payer payments	3,116	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,987,071	61.00
62.00	Deductibles billed to program beneficiaries	869,092	62.00
63.00	Coinsurance billed to program beneficiaries	4,081	63.00
64.00	Allowable bad debts (see instructions)	56,577	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	36,775	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,272	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,150,673	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	21,549	70.93
70.94	HRR adjustment amount (see instructions)	-402	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2021	876,768	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	283,862	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,332,450	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,948,936	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,383,514	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		276,418	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0057

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

Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2022 1:49 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,745,716	0	5,745,716		5,745,716	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,999,746	0		1,999,746	1,999,746	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	63,879	0	63,879		63,879	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	5,779,811	0	4,162,528	1,617,283	5,779,811	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0924	0.0924	0.0924	0.0924		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	178,920	0	132,726	46,194	178,920	11.00
11.01	Uncompensated care payments	36.00	2,375,205	0	1,892,385	482,820	2,375,205	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	10,363,466	0	7,834,706	2,528,760	10,363,466	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,363,466	0	7,834,706	2,528,760	10,363,466	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	595,340	0	446,994	148,346	595,340	16.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/31/2022 1:49 pm
	Title XVIII	Hospital	PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	31,381	0	20,552	10,829	31,381	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,302,252	2,687,935	10,990,187	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	587,897	0	439,551	148,346	587,897	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	7,443	0	7,443	0	7,443	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	595,340	0	446,994	148,346	595,340	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.105606	0.105606		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			876,768		876,768	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				283,862	283,862	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part B | Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,867,460	2.00
3.00	OPPS payments	12,877,212	3.00
4.00	Outlier payment (see instructions)	5,314	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)	0	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)	0	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)	12,882,526	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	292	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,175,278	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	10,706,956	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	10,706,956	30.00
31.00	Primary payer payments	344	31.00
32.00	Subtotal (line 30 minus line 31)	10,706,612	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)	181,310	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	117,852	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,390	36.00
37.00	Subtotal (see instructions)	10,824,464	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)	10,824,464	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	10,860,515	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)	-36,051	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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2022 1:49 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,901,636		10,860,515	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	12/31/2021	47,300		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)		47,300		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)		9,948,936		10,860,515	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		1,383,514		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		36,051	6.02
7.00	Total Medicare program liability (see instructions)		11,332,450		10,824,464	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: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/31/2022 1:49 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part VII Date/Time Prepared: 5/31/2022 1:49 pm

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		7,932,938	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	7,932,938	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	7,932,938	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	12,193,578	71,764,396	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)	12,193,578	71,764,396	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)	12,193,578	71,764,396	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	12,193,578	63,831,458	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	7,932,938	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	7,932,938	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	7,932,938	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	7,932,938	36.00
37.00	TO ZERO OUT MEDICAID	0	-7,932,938	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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/31/2022 1:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-26,033,853	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	16,196,401	0	0	0	4.00
5.00	Other receivable	93,800	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,585,659	0	0	0	7.00
8.00	Prepaid expenses	204,896	0	0	0	8.00
9.00	Other current assets	242,480	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)	-7,710,617	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	2,743,633	0	0	0	13.00
14.00	Accumulated depreciation	-1,789,511	0	0	0	14.00
15.00	Buildings	62,795,616	0	0	0	15.00
16.00	Accumulated depreciation	-28,712,104	0	0	0	16.00
17.00	Leasehold improvements	2,176,996	0	0	0	17.00
18.00	Accumulated depreciation	-1,823,684	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	74,818,563	0	0	0	23.00
24.00	Accumulated depreciation	-39,717,448	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	18,203,972	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	88,696,033	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,006,598	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	62,460	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,069,058	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	85,054,474	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,904,258	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,208,506	0	0	0	38.00
39.00	Payroll taxes payable	93,452	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-2,549,218	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,656,998	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	1,053,223	0	0	0	46.00
47.00	Notes payable	441,142	0	0	0	47.00
48.00	Unsecured loans	196,168	0	0	0	48.00
49.00	Other long term liabilities	643,313	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,333,846	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,990,844	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	76,063,630				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)	76,063,630	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	85,054,474	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/31/2022 1:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,362,335		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		47,583,301				2.00
3.00	Total (sum of line 1 and line 2)		75,945,636		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)		75,945,636		0		11.00
12.00	FUND EQUITY CHANGES	76,504		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)		76,504		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		75,869,132		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	FUND EQUITY CHANGES		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: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2022 1:49 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,678,614		14,678,614	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)	14,678,614		14,678,614	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	5,975,172		5,975,172	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,975,172		5,975,172	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,653,786		20,653,786	17.00
18.00	Ancillary services	87,555,745	338,565,764	426,121,509	18.00
19.00	Outpatient services	11,777,367	97,131,349	108,908,716	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER REVENUE	58,368	41,957,711	42,016,079	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	120,045,266	477,654,824	597,700,090	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		99,727,381		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)		99,727,381		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/31/2022 1:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	597,700,090	1.00
2.00	Less contractual allowances and discounts on patients' accounts	420,069,091	2.00
3.00	Net patient revenues (line 1 minus line 2)	177,630,999	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	99,727,381	4.00
5.00	Net income from service to patients (line 3 minus line 4)	77,903,618	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	-61,798	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	74,823	20.00
21.00	Rental of vending machines	3,393	21.00
22.00	Rental of hospital space	1,646,649	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	5,086,534	24.00
24.01	RECONC ITEM - PATIENT REVENUE	-41,454,251	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-34,704,650	25.00
26.00	Total (line 5 plus line 25)	43,198,968	26.00
27.00	TOTAL NON OPERATING REVENUE	-717,314	27.00
27.01	RECONC ITEM - EXPENSES	-3,667,019	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-4,384,333	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	47,583,301	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0057	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/31/2022 1:49 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	587,897	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	7,443	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.80	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	595,340	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00