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: 15-1328	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 1:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 1:13 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 INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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	Michael Craig		Y	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	Michael Craig			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			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	-260,596	-1,432,926	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	-260,596	-1,432,926	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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 1:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	O	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	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	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.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 1:13 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 1:13 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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 1:13 pm

		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: 15-1328	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 1:13 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 1:13 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	52,499	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 1:13 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: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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.	Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	204	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 1:13 pm

		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	02/25/2022	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	04/01/2022	Y	04/01/2022	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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 1:13 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.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1328	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 1:13 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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 1:13 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	19	6,935	142,488.00	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)		19	6,935	142,488.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	38,928.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	181,416.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 1:13 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)	2,551	127	5,937			1.00
2.00	HMO and other (see instructions)	2,070	712				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	1			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,551	127	5,938			7.00
8.00	INTENSIVE CARE UNIT	664	30	1,622			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)	3,215	157	7,560	0.00	260.34	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)			41			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	260.34	27.00
28.00	Observation Bed Days		21	1,195			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2022 1:13 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	706	29	1,598	1.00
2.00	HMO and other (see instructions)			399	174		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	706	29	1,598	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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 1:13 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)			0.213445	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			7,929,517	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			50,468,217	6.00
7.00	Medicaid cost (line 1 times line 6)			10,772,189	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			2,842,672	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)			9,905	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			90,703	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			19,360	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)			9,455	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,852,127	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)	4,487,417	710,892	5,198,309	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	957,817	710,892	1,668,709	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)	957,817	710,892	1,668,709	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)			6,240,311	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,270,888	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,955,213	27.01
28.00	Non-Medicare bad debt expense (see instructions)			4,285,098	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,598,958	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,267,667	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,119,794	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 1:13 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	509,897	509,897	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,325,665	1,325,665	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	80,085	80,085	3,689,003	3,769,088	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	974,880	14,059,386	15,034,266	-484,324	14,549,942	5.00
7.00	00700	OPERATION OF PLANT	796,630	1,759,175	2,555,805	-382,853	2,172,952	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	147,691	147,691	0	147,691	8.00
9.00	00900	HOUSEKEEPING	430,733	469,334	900,067	-107,790	792,277	9.00
10.00	01000	DIETARY	377,440	591,690	969,130	-313,321	655,809	10.00
11.00	01100	CAFETERIA	0	0	0	215,792	215,792	11.00
13.00	01300	NURSING ADMINISTRATION	3,114,908	892,812	4,007,720	-2,233,144	1,774,576	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,339	63,185	132,524	458,457	590,981	14.00
15.00	01500	PHARMACY	806,293	12,328,772	13,135,065	-11,584,789	1,550,276	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	42,591	42,591	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,640,313	2,898,823	6,539,136	-255,917	6,283,219	30.00
31.00	03100	INTENSIVE CARE UNIT	1,659,066	996,689	2,655,755	-206,039	2,449,716	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,237,982	2,240,346	3,478,328	-649,875	2,828,453	50.00
51.00	05100	RECOVERY ROOM	405,491	112,157	517,648	31,196	548,844	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,899	1,154,331	2,225,230	-764,425	1,460,805	54.00
56.00	05600	RADIOISOTOPE	98,848	253,909	352,757	-113,413	239,344	56.00
57.00	05700	CT SCAN	415,169	284,032	699,201	-173,958	525,243	57.00
58.00	05800	MRI	241,678	202,733	444,411	-89,838	354,573	58.00
60.00	06000	LABORATORY	305,024	3,758,535	4,063,559	-29,950	4,033,609	60.00
65.00	06500	RESPIRATORY THERAPY	1,043,702	469,677	1,513,379	-88,691	1,424,688	65.00
66.00	06600	PHYSICAL THERAPY	681,142	236,461	917,603	-118,515	799,088	66.00
67.00	06700	OCCUPATIONAL THERAPY	372,509	90,391	462,900	-67,065	395,835	67.00
68.00	06800	SPEECH PATHOLOGY	78,574	16,142	94,716	-8,734	85,982	68.00
69.00	06900	ELECTROCARDIOLOGY	415,450	875,268	1,290,718	-300,408	990,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	240,937	240,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	176,356	176,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,844,529	11,844,529	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	73,476	73,476	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	934,159	476,927	1,411,086	-274,777	1,136,309	90.00
90.01	09001	CLINIC - DIABETES	1,110	57,270	58,380	-190	58,190	90.01
91.00	09100	EMERGENCY	2,721,345	2,218,877	4,940,222	-371,578	4,568,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,892,684	46,734,698	68,627,382	-11,695	68,615,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,202	18,564	42,766	-17,260	25,506	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,423	4,734	24,157	62,075	86,232	192.00
194.00	07950	OCCUPATIONAL HEALTH	251	2,534	2,785	13,987	16,772	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	134,972	65,461	200,433	-47,107	153,326	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	22,071,532	46,825,991	68,897,523	0	68,897,523	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 1:13 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	258,469	768,366		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	311,424	1,637,089		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	460,257	4,229,345		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	683,864	15,233,806		5.00
7.00	00700	OPERATION OF PLANT	-1,243	2,171,709		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-646	147,045		8.00
9.00	00900	HOUSEKEEPING	0	792,277		9.00
10.00	01000	DIETARY	-13,281	642,528		10.00
11.00	01100	CAFETERIA	-36,873	178,919		11.00
13.00	01300	NURSING ADMINISTRATION	14,744	1,789,320		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	590,981		14.00
15.00	01500	PHARMACY	264,482	1,814,758		15.00
17.00	01700	SOCIAL SERVICE	0	42,591		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,159,417	5,123,802		30.00
31.00	03100	INTENSIVE CARE UNIT	-290,366	2,159,350		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,289,434	1,539,019		50.00
51.00	05100	RECOVERY ROOM	0	548,844		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-117,632	1,343,173		54.00
56.00	05600	RADIOISOTOPE	0	239,344		56.00
57.00	05700	CT SCAN	0	525,243		57.00
58.00	05800	MRI	0	354,573		58.00
60.00	06000	LABORATORY	-306,745	3,726,864		60.00
65.00	06500	RESPIRATORY THERAPY	-75,915	1,348,773		65.00
66.00	06600	PHYSICAL THERAPY	122,867	921,955		66.00
67.00	06700	OCCUPATIONAL THERAPY	-9,818	386,017		67.00
68.00	06800	SPEECH PATHOLOGY	0	85,982		68.00
69.00	06900	ELECTROCARDIOLOGY	0	990,310		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	240,937		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	176,356		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,844,529		73.00
76.97	07697	CARDIAC REHABILITATION	0	73,476		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-25	1,136,284		90.00
90.01	09001	CLINIC - DIABETES	-56,640	1,550		90.01
91.00	09100	EMERGENCY	-251,670	4,316,974		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,493,598	67,122,089		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,506		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	86,232		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	16,772		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	153,326		194.02
194.03	07953	HOME CARE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,493,598	67,403,925		200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 1:13 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,613,755		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
	0		0	3,613,755		
	B - DIETARY/CAFETERIA					
1.00	CAFETERIA	11.00	72,561	143,231		1.00
	0		72,561	143,231		
	C - CAPITAL LEASE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	63,283		1.00
	0		0	63,283		
	D - CARDIOLOGY					
1.00	CARDIAC REHABILITATION	76.97	62,301	11,175		1.00
	0		62,301	11,175		
	E - DEPR EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	459,496		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,312,055		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	1,771,551		
	F - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,844,529		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

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 1:13 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	0		0	11,844,529		
	G - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	176,356		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	176,356		
	H - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		76,331		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		30,100		2.00
3.00	HOUSEKEEPING	9.00		4,044		3.00
4.00	NURSING ADMINISTRATION	13.00		20,375		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00		95		5.00
6.00	OPERATING ROOM	50.00		33,831		6.00
7.00	RADIOISOTOPE	56.00		6,362		7.00
8.00	PHYSICAL THERAPY	66.00		5,205		8.00
9.00	SPEECH PATHOLOGY	68.00		1,673		9.00
10.00	CLINIC	90.00		6,352		10.00
11.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		7,965		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	192,333		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	240,937		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
	0		0	240,937		
	J - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50,401		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,610		2.00
	0		0	64,011		
	L - SOCIAL WORKER					
1.00	SOCIAL SERVICE	17.00	42,591	0		1.00
	0		42,591	0		
	M - NONBILLABLE DRUGS					
1.00	PHARMACY	15.00	0	264,115		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

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 1:13 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	264,115		
	N - NONBILLABLE MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00		586,537		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		15,673		2.00
3.00	OPERATION OF PLANT	7.00		34		3.00
4.00	HOUSEKEEPING	9.00		269		4.00
5.00	DIETARY	10.00		212		5.00
6.00	NURSING ADMINISTRATION	13.00		916		6.00
7.00	RADIOISOTOPE	56.00		6,927		7.00
8.00	CT SCAN	57.00		3,723		8.00
9.00	MRI	58.00		329		9.00
10.00	PHYSICAL THERAPY	66.00		623		10.00
11.00	CLINIC - DIABETES	90.01		4		11.00
12.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		25		12.00
	0		0	615,272		
	O - PREMIUM WAGES					
1.00	ADULTS & PEDIATRICS	30.00	544,249	36,666		1.00
2.00	INTENSIVE CARE UNIT	31.00	206,788	13,931		2.00
3.00	OPERATING ROOM	50.00	299,299	20,164		3.00
4.00	RECOVERY ROOM	51.00	114,035	7,682		4.00
5.00	RESPIRATORY THERAPY	65.00	242,698	16,351		5.00
6.00	EMERGENCY	91.00	324,355	21,852		6.00
	TOTALS		1,731,424	116,646		
	P - COMMUNITY BENEFIT					
1.00	OCCUPATIONAL HEALTH	194.00	0	14,158		1.00
	TOTALS		0	14,158		
500.00	Grand Total: Increases		1,908,877	19,131,352		500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 1:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00		155,330	0		1.00
2.00	OPERATION OF PLANT	7.00		172,036	0		2.00
3.00	HOUSEKEEPING	9.00		108,509	0		3.00
4.00	DIETARY	10.00		80,718	0		4.00
5.00	NURSING ADMINISTRATION	13.00		338,005	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00		51,735	0		6.00
7.00	PHARMACY	15.00		126,875	0		7.00
8.00	ADULTS & PEDIATRICS	30.00		604,224	0		8.00
9.00	INTENSIVE CARE UNIT	31.00		262,561	0		9.00
10.00	OPERATING ROOM	50.00		163,760	0		10.00
11.00	RECOVERY ROOM	51.00		77,986	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00		219,019	0		12.00
13.00	RADIOISOTOPE	56.00		22,752	0		13.00
14.00	CT SCAN	57.00		84,868	0		14.00
15.00	MRI	58.00		40,227	0		15.00
16.00	LABORATORY	60.00		29,950	0		16.00
17.00	RESPIRATORY THERAPY	65.00		135,562	0		17.00
18.00	PHYSICAL THERAPY	66.00		116,088	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00		62,282	0		19.00
20.00	SPEECH PATHOLOGY	68.00		10,407	0		20.00
21.00	ELECTROCARDIOLOGY	69.00		49,033	0		21.00
22.00	CLINIC	90.00		201,312	0		22.00
23.00	EMERGENCY	91.00		432,010	0		23.00
24.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00		16,624	0		24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00		1,160	0		25.00
26.00	OCCUPATIONAL HEALTH	194.00		7	0		26.00
27.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		50,715	0		27.00
	0		0	3,613,755			
	B - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	72,561	143,231	0		1.00
	0		72,561	143,231			
	C - CAPITAL LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,283	0		1.00
	0		0	63,283			
	D - CARDIOLOGY						
1.00	ELECTROCARDIOLOGY	69.00	62,301	11,175	0		1.00
	0		62,301	11,175			
	E - DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,083	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	233,266	9		2.00
3.00	OPERATION OF PLANT	7.00	0	202,325	0		3.00
4.00	HOUSEKEEPING	9.00	0	3,594	0		4.00
5.00	DIETARY	10.00	0	14,096	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	25,577	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	71,434	0		7.00
8.00	PHARMACY	15.00	0	45,155	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	42,389	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	88,465	0		10.00
11.00	OPERATING ROOM	50.00	0	261,171	0		11.00
12.00	RECOVERY ROOM	51.00	0	3,834	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	434,998	0		13.00
14.00	RADIOISOTOPE	56.00	0	86,934	0		14.00
15.00	CT SCAN	57.00	0	632	0		15.00
16.00	MRI	58.00	0	26,567	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	28,709	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	7,386	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	107,059	0		19.00
20.00	CLINIC	90.00	0	1,700	0		20.00
21.00	CLINIC - DIABETES	90.01	0	194	0		21.00
22.00	EMERGENCY	91.00	0	80,514	0		22.00
23.00	OCCUPATIONAL HEALTH	194.00	0	87	0		23.00
24.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	4,382	0		24.00
	0		0	1,771,551			
	F - BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00		52	0		1.00
2.00	PHARMACY	15.00		11,632,641	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		681	0		3.00
4.00	INTENSIVE CARE UNIT	31.00		831	0		4.00
5.00	OPERATING ROOM	50.00		4,473	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00		16,966	0		6.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 1:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	RADIOISOTOPE	56.00		16,210	0		7.00
8.00	CT SCAN	57.00		90,583	0		8.00
9.00	MRI	58.00		17,327	0		9.00
10.00	RESPIRATORY THERAPY	65.00		5,471	0		10.00
11.00	PHYSICAL THERAPY	66.00		22	0		11.00
12.00	ELECTROCARDIOLOGY	69.00		56,506	0		12.00
13.00	CLINIC	90.00		74	0		13.00
14.00	EMERGENCY	91.00		2,692	0		14.00
	0		0	11,844,529			
	G - IMPLANT SUPPLIES						
1.00	PHARMACY	15.00		293	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		169	0		2.00
3.00	INTENSIVE CARE UNIT	31.00		13	0		3.00
4.00	OPERATING ROOM	50.00		152,603	0		4.00
5.00	CLINIC	90.00		22,135	0		5.00
6.00	EMERGENCY	91.00		1,143	0		6.00
	0		0	176,356			
	H - ACCRUED PTO						
1.00	DIETARY	10.00		2,927	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00		25,382	0		2.00
3.00	CT SCAN	57.00		66	0		3.00
4.00	OPERATION OF PLANT	7.00		8,521	0		4.00
5.00	PHARMACY	15.00		6,806	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		56,761	0		6.00
7.00	INTENSIVE CARE UNIT	31.00		8,549	0		7.00
8.00	RECOVERY ROOM	51.00		8,701	0		8.00
9.00	MRI	58.00		5,951	0		9.00
10.00	RESPIRATORY THERAPY	65.00		26,851	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00		4,783	0		11.00
12.00	ELECTROCARDIOLOGY	69.00		6,409	0		12.00
13.00	EMERGENCY	91.00		29,913	0		13.00
14.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00		636	0		14.00
15.00	OCCUPATIONAL HEALTH	194.00		77	0		15.00
	0		0	192,333			
	I - BILLABLE MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00		49	0		1.00
2.00	OPERATION OF PLANT	7.00		5	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		1,681	0		3.00
4.00	PHARMACY	15.00		5,120	0		4.00
5.00	ADULTS & PEDIATRICS	30.00		11,914	0		5.00
6.00	INTENSIVE CARE UNIT	31.00		6,169	0		6.00
7.00	OPERATING ROOM	50.00		181,362	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		2,248	0		8.00
9.00	RADIOISOTOPE	56.00		75	0		9.00
10.00	CT SCAN	57.00		44	0		10.00
11.00	MRI	58.00		5	0		11.00
12.00	RESPIRATORY THERAPY	65.00		1,687	0		12.00
13.00	PHYSICAL THERAPY	66.00		847	0		13.00
14.00	ELECTROCARDIOLOGY	69.00		1,496	0		14.00
15.00	CLINIC	90.00		7,895	0		15.00
16.00	EMERGENCY	91.00		20,306	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00		34	0		17.00
	0		0	240,937			
	J - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	64,011	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	64,011			
	L - SOCIAL WORKER						
1.00	NURSING ADMINISTRATION	13.00	42,591	0	0		1.00
	0		42,591	0			
	M - NONBILLABLE DRUGS						
1.00	NURSING ADMINISTRATION	13.00	0	192	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,273	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	40,977	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	29,103	0		4.00
5.00	OPERATING ROOM	50.00	0	26,647	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,617	0		6.00
7.00	RADIOISOTOPE	56.00	0	731	0		7.00
8.00	CT SCAN	57.00	0	1,488	0		8.00
9.00	MRI	58.00	0	90	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	2,953	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	2,141	0		11.00
12.00	CLINIC	90.00	0	32,575	0		12.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 1:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	EMERGENCY	91.00	0	108,328	0		13.00
	0		0	264,115			
	N - NONBILLABLE MEDICAL SUPPLIES						
1.00	PHARMACY	15.00		32,014	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		79,717	0		2.00
3.00	INTENSIVE CARE UNIT	31.00		31,067	0		3.00
4.00	OPERATING ROOM	50.00		213,153	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		50,195	0		5.00
6.00	RESPIRATORY THERAPY	65.00		146,507	0		6.00
7.00	ELECTROCARDIOLOGY	69.00		4,288	0		7.00
8.00	CLINIC	90.00		15,438	0		8.00
9.00	EMERGENCY	91.00		42,879	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00		14	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	0		0	615,272			
	O - PREMIUM WAGES						
1.00	NURSING ADMINISTRATION	13.00	1,731,424	116,646	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		1,731,424	116,646			
	P - COMMUNITY BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,158	0		1.00
	TOTALS		0	14,158			
500.00	Grand Total: Decreases		1,908,877	19,131,352			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 1:13 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	931,334	0	0	0	0	1.00
2.00	Land Improvements	1,119,735	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,066,348	0	0	0	0	3.00
4.00	Building Improvements	5,169,109	646,650	0	646,650	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,393,350	1,238,260	0	1,238,260	493,526	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,679,876	1,884,910	0	1,884,910	493,526	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,679,876	1,884,910	0	1,884,910	493,526	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	931,334	0	1.00
2.00	Land Improvements	1,119,735	938,013	2.00
3.00	Buildings and Fixtures	14,066,348	5,397,710	3.00
4.00	Building Improvements	5,815,759	2,252,174	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	16,138,084	7,412,999	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,071,260	16,000,896	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	38,071,260	16,000,896	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2022 1:13 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	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2022 1:13 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	21,933,176	0	21,933,176	0.576108	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,138,084	0	16,138,084	0.423892	0	2.00
3.00	Total (sum of lines 1-2)	38,071,260	0	38,071,260	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	459,492	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,623,479	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,082,971	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	258,473	50,401	0	0	768,366	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,610	0	0	1,637,089	2.00
3.00	Total (sum of lines 1-2)	258,473	64,011	0	0	2,405,455	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 1:13 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)	B	73,086	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,612,827			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	11,402,016			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-36,873	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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	A	-256	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-10,693	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 1:13 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	
34.00	MISCELLANEOUS INCOME	B	-529	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-646	LAUNDRY & LINEN SERVICE	8.00	0	35.00
36.00	MISCELLANEOUS INCOME	B	-28,728	NURSING ADMINISTRATION	13.00	0	36.00
37.00	MISCELLANEOUS INCOME	B	-9,300	RADIOLOGY-DIAGNOSTIC	54.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-75,915	RESPIRATORY THERAPY	65.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-9,818	OCCUPATIONAL THERAPY	67.00	0	39.00
45.00	INVESTMENT FEES	B	7,371	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	PHONES	A	-4	CAP REL COSTS-BLDG & FIXT	1.00	9	45.01
45.02	PHONES	A	-2,935	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03	PHONES	A	-5,281	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PHONES	A	-35,776	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	HAF	A	-3,499,512	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	CABLE	A	-714	OPERATION OF PLANT	7.00	0	45.06
45.07	MARKETING	A	-19,691	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	MARKETING	A	-40	NURSING ADMINISTRATION	13.00	0	45.08
45.09	MARKETING	A	-4	RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	MARKETING	A	-25	CLINIC	90.00	0	45.10
45.11	BENEFITS	A	-3,613,754	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.11
45.12	CONTRIBUTION EXPENSE	A	-164	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.12
45.13	CONTRIBUTION EXPENSE	A	-12,586	RADIOLOGY-DIAGNOSTIC	54.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,493,598				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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 1:13 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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	185,387	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	314,615	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,976,808	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	11,219,129	8,731,736	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	174,093	71,445	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	2,495,529	740,757	4.02
4.03	10.00	DIETARY	RELATED PARTY	0	13,281	4.03
4.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	104,564	61,052	4.04
4.05	15.00	PHARMACY	RELATED PARTY	597,135	332,653	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	50,101	0	4.06
4.07	66.00	PHYSICAL THERAPY	RELATED PARTY	163,593	40,726	4.07
4.08	90.01	CLINIC - DIABETES	RELATED PARTY	0	56,640	4.08
4.09	91.00	EMERGENCY	EMERGENCY ROOM	2,858,494	689,142	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	1,248	1,248	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	2,880	2,880	4.11
4.12	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	317	317	4.12
4.13	10.00	DIETARY	SHARED EMPLOYEES	38,105	38,105	4.13
4.14	15.00	PHARMACY	SHARED EMPLOYEES	244	244	4.14
4.15	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	1,159,317	1,159,317	4.15
4.16	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	289,986	289,986	4.16
4.17	60.00	LABORATORY	SHARED EMPLOYEES	3,650,125	3,650,125	4.17
4.18	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	21,046	21,046	4.18
4.19	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	42	42	4.19
4.20	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	562,390	562,390	4.20
4.21	90.00	CLINIC	SHARED EMPLOYEES	56,252	56,252	4.21
4.22	90.01	CLINIC - DIABETES	SHARED EMPLOYEES	1,110	1,110	4.22
4.23	192.00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	-1,037	-1,037	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			27,921,473	16,519,457	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:					
6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 1:13 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	185,387	11		1.00
2.00	314,615	9		2.00
3.00	3,976,808	0		3.00
4.00	2,487,393	0		4.00
4.01	102,648	0		4.01
4.02	1,754,772	0		4.02
4.03	-13,281	0		4.03
4.04	43,512	0		4.04
4.05	264,482	0		4.05
4.06	50,101	0		4.06
4.07	122,867	0		4.07
4.08	-56,640	0		4.08
4.09	2,169,352	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
5.00	11,402,016			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 1:13 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	30.00	ADULTS & PEDIATRICS	1,159,417	1,159,417	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	290,366	290,366	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,289,434	1,289,434	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	145,843	145,843	0	0	0	4.00
5.00	60.00	LABORATORY	312,533	306,745	5,788	0	0	5.00
6.00	91.00	EMERGENCY	2,611,573	2,421,022	190,551	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			5,809,166	5,612,827	196,339		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,159,417		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	290,366		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,289,434		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	145,843		4.00
5.00	60.00	LABORATORY	0	0	0	306,745		5.00
6.00	91.00	EMERGENCY	0	0	0	2,421,022		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	5,612,827		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	768,366	768,366				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,637,089		1,637,089			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,229,345	2,413	6,969	4,238,727		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,233,806	112,553	325,153	187,221	15,858,733	5.00
7.00	00700	OPERATION OF PLANT	2,171,709	85,020	245,613	152,989	2,655,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	147,045	3,642	10,520	0	161,207	8.00
9.00	00900	HOUSEKEEPING	792,277	8,325	24,049	82,720	907,371	9.00
10.00	01000	DIETARY	642,528	18,938	54,709	58,550	774,725	10.00
11.00	01100	CAFETERIA	178,919	8,522	24,618	13,935	225,994	11.00
13.00	01300	NURSING ADMINISTRATION	1,789,320	25,776	74,464	257,512	2,147,072	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	590,981	20,483	59,174	13,316	683,954	14.00
15.00	01500	PHARMACY	1,814,758	5,811	16,788	154,845	1,992,202	15.00
17.00	01700	SOCIAL SERVICE	42,591	793	2,292	8,179	53,855	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,123,802	40,967	118,348	803,625	6,086,742	30.00
31.00	03100	INTENSIVE CARE UNIT	2,159,350	10,737	31,018	358,328	2,559,433	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,539,019	50,626	146,252	295,227	2,031,124	50.00
51.00	05100	RECOVERY ROOM	548,844	0	0	99,772	648,616	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,343,173	22,589	65,256	205,661	1,636,679	54.00
56.00	05600	RADIOISOTOPE	239,344	0	0	18,983	258,327	56.00
57.00	05700	CT SCAN	525,243	4,637	13,396	79,731	623,007	57.00
58.00	05800	MRI	354,573	4,921	14,217	46,413	420,124	58.00
60.00	06000	LABORATORY	3,726,864	21,300	61,532	58,578	3,868,274	60.00
65.00	06500	RESPIRATORY THERAPY	1,348,773	9,925	28,673	247,047	1,634,418	65.00
66.00	06600	PHYSICAL THERAPY	921,955	10,535	30,435	130,810	1,093,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	386,017	4,853	14,018	71,538	476,426	67.00
68.00	06800	SPEECH PATHOLOGY	85,982	1,509	4,359	15,090	106,940	68.00
69.00	06900	ELECTROCARDIOLOGY	990,310	22,905	66,170	67,820	1,147,205	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	240,937	0	0	0	240,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,356	0	0	0	176,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,844,529	0	0	0	11,844,529	73.00
76.97	07697	CARDIAC REHABILITATION	73,476	1,642	4,743	11,965	91,826	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,136,284	28,083	81,129	179,401	1,424,897	90.00
90.01	09001	CLINIC - DIABETES	1,550	2,454	7,089	213	11,306	90.01
91.00	09100	EMERGENCY	4,316,974	22,552	65,150	584,911	4,989,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,122,089	552,511	1,596,134	4,204,380	66,830,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,506	4,403	12,720	4,648	47,277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,232	176,218	0	3,730	266,180	192.00
194.00	07950	OCCUPATIONAL HEALTH	16,772	9,774	28,235	48	54,829	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	153,326	25,460	0	25,921	204,707	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	67,403,925	768,366	1,637,089	4,238,727	67,403,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,858,733					5.00
7.00	00700	OPERATION OF PLANT	816,958	3,472,289				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,598	22,247	233,052			8.00
9.00	00900	HOUSEKEEPING	279,168	50,855	0	1,237,394		9.00
10.00	01000	DIETARY	238,357	115,693	0	66,059	1,194,834	10.00
11.00	01100	CAFETERIA	69,531	52,060	0	29,726	0	11.00
13.00	01300	NURSING ADMINISTRATION	660,583	157,470	0	89,913	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	210,430	125,135	0	71,451	0	14.00
15.00	01500	PHARMACY	612,935	35,501	0	20,270	0	15.00
17.00	01700	SOCIAL SERVICE	16,569	4,847	0	2,768	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,872,690	250,270	183,044	142,901	938,448	30.00
31.00	03100	INTENSIVE CARE UNIT	787,453	65,594	50,008	37,453	256,386	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	624,910	309,279	0	176,594	0	50.00
51.00	05100	RECOVERY ROOM	199,558	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,552	137,996	0	78,794	0	54.00
56.00	05600	RADIOISOTOPE	79,479	0	0	0	0	56.00
57.00	05700	CT SCAN	191,679	28,328	0	16,175	0	57.00
58.00	05800	MRI	129,258	30,065	0	17,167	0	58.00
60.00	06000	LABORATORY	1,190,140	130,123	0	74,298	0	60.00
65.00	06500	RESPIRATORY THERAPY	502,856	60,634	0	34,621	0	65.00
66.00	06600	PHYSICAL THERAPY	336,506	64,361	0	36,749	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	146,581	29,645	0	16,927	0	67.00
68.00	06800	SPEECH PATHOLOGY	32,902	9,218	0	5,264	0	68.00
69.00	06900	ELECTROCARDIOLOGY	352,957	139,929	0	79,898	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	74,128	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,259	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,644,149	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	28,252	10,031	0	5,728	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	438,394	171,563	0	97,961	0	90.00
90.01	09001	CLINIC - DIABETES	3,478	14,990	0	8,559	0	90.01
91.00	09100	EMERGENCY	1,535,131	137,772	0	78,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,682,441	2,153,606	233,052	1,187,942	1,194,834	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,546	26,899	0	15,359	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	81,895	1,076,538	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	16,869	59,710	0	34,093	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	62,982	155,536	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,858,733	3,472,289	233,052	1,237,394	1,194,834	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	377,311					11.00
13.00	01300	NURSING ADMINISTRATION	23,037	3,078,075				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,952	0	1,093,922			14.00
15.00	01500	PHARMACY	14,294	0	34,116	2,709,318		15.00
17.00	01700	SOCIAL SERVICE	1,113	0	0	0	79,152	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,436	1,255,206	83,275	9,171	62,168	30.00
31.00	03100	INTENSIVE CARE UNIT	29,442	476,616	40,210	6,514	16,984	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,021	133,167	232,809	5,964	0	50.00
51.00	05100	RECOVERY ROOM	6,582	132,195	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,828	0	53,715	3,495	0	54.00
56.00	05600	RADIOISOTOPE	2,355	0	594	164	0	56.00
57.00	05700	CT SCAN	10,857	0	3,455	333	0	57.00
58.00	05800	MRI	5,872	0	183	20	0	58.00
60.00	06000	LABORATORY	30,217	2,592	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	20,989	648	153,187	661	0	65.00
66.00	06600	PHYSICAL THERAPY	15,536	0	274	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,453	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,533	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,502	73,550	6,243	479	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	244,196	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	178,741	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,650,981	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,113	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,779	271,843	17,383	7,291	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	50,560	730,962	45,526	24,245	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	369,471	3,076,779	1,093,907	2,709,318	79,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,113	648	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	403	0	15	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,324	648	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	377,311	3,078,075	1,093,922	2,709,318	79,152	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,958,351	0	10,958,351		30.00
31.00	03100	INTENSIVE CARE UNIT	4,326,093	0	4,326,093		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,534,868	0	3,534,868		50.00
51.00	05100	RECOVERY ROOM	986,951	0	986,951		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,436,059	0	2,436,059		54.00
56.00	05600	RADIOISOTOPE	340,919	0	340,919		56.00
57.00	05700	CT SCAN	873,834	0	873,834		57.00
58.00	05800	MRI	602,689	0	602,689		58.00
60.00	06000	LABORATORY	5,295,644	0	5,295,644		60.00
65.00	06500	RESPIRATORY THERAPY	2,408,014	0	2,408,014		65.00
66.00	06600	PHYSICAL THERAPY	1,547,161	0	1,547,161		66.00
67.00	06700	OCCUPATIONAL THERAPY	676,032	0	676,032		67.00
68.00	06800	SPEECH PATHOLOGY	155,857	0	155,857		68.00
69.00	06900	ELECTROCARDIOLOGY	1,807,763	0	1,807,763		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	559,261	0	559,261		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	409,356	0	409,356		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,139,659	0	18,139,659		73.00
76.97	07697	CARDIAC REHABILITATION	136,950	0	136,950		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,451,111	0	2,451,111		90.00
90.01	09001	CLINIC - DIABETES	38,333	0	38,333		90.01
91.00	09100	EMERGENCY	7,592,449	0	7,592,449		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,277,354	0	65,277,354		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	105,842	0	105,842		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,425,031	0	1,425,031		192.00
194.00	07950	OCCUPATIONAL HEALTH	165,501	0	165,501		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	430,197	0	430,197		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	67,403,925	0	67,403,925		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS 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	2,413	6,969	9,382	9,382	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	112,553	325,153	437,706	414	5.00
7.00	00700	OPERATION OF PLANT	0	85,020	245,613	330,633	339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,642	10,520	14,162	0	8.00
9.00	00900	HOUSEKEEPING	0	8,325	24,049	32,374	183	9.00
10.00	01000	DIETARY	0	18,938	54,709	73,647	130	10.00
11.00	01100	CAFETERIA	0	8,522	24,618	33,140	31	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,776	74,464	100,240	570	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,483	59,174	79,657	29	14.00
15.00	01500	PHARMACY	0	5,811	16,788	22,599	343	15.00
17.00	01700	SOCIAL SERVICE	0	793	2,292	3,085	18	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,967	118,348	159,315	1,783	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,737	31,018	41,755	793	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,626	146,252	196,878	653	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	221	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,589	65,256	87,845	455	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	42	56.00
57.00	05700	CT SCAN	0	4,637	13,396	18,033	176	57.00
58.00	05800	MRI	0	4,921	14,217	19,138	103	58.00
60.00	06000	LABORATORY	0	21,300	61,532	82,832	130	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,925	28,673	38,598	547	65.00
66.00	06600	PHYSICAL THERAPY	0	10,535	30,435	40,970	289	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,853	14,018	18,871	158	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,509	4,359	5,868	33	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,905	66,170	89,075	150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,642	4,743	6,385	26	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	28,083	81,129	109,212	397	90.00
90.01	09001	CLINIC - DIABETES	0	2,454	7,089	9,543	0	90.01
91.00	09100	EMERGENCY	0	22,552	65,150	87,702	1,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	552,511	1,596,134	2,148,645	9,307	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,403	12,720	17,123	10	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	176,218	0	176,218	8	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	9,774	28,235	38,009	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	25,460	0	25,460	57	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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	768,366	1,637,089	2,405,455	9,382	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	438,120					5.00
7.00	00700	OPERATION OF PLANT	22,570	353,542				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,370	2,265	17,797			8.00
9.00	00900	HOUSEKEEPING	7,713	5,178	0	45,448		9.00
10.00	01000	DIETARY	6,585	11,780	0	2,426	94,568	10.00
11.00	01100	CAFETERIA	1,921	5,301	0	1,092	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,250	16,033	0	3,302	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,814	12,741	0	2,624	0	14.00
15.00	01500	PHARMACY	16,934	3,615	0	745	0	15.00
17.00	01700	SOCIAL SERVICE	458	494	0	102	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,737	25,482	13,978	5,249	74,276	30.00
31.00	03100	INTENSIVE CARE UNIT	21,755	6,679	3,819	1,376	20,292	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,265	31,490	0	6,485	0	50.00
51.00	05100	RECOVERY ROOM	5,513	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,912	14,051	0	2,894	0	54.00
56.00	05600	RADIOISOTOPE	2,196	0	0	0	0	56.00
57.00	05700	CT SCAN	5,296	2,884	0	594	0	57.00
58.00	05800	MRI	3,571	3,061	0	631	0	58.00
60.00	06000	LABORATORY	32,880	13,249	0	2,729	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,893	6,174	0	1,272	0	65.00
66.00	06600	PHYSICAL THERAPY	9,297	6,553	0	1,350	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,050	3,018	0	622	0	67.00
68.00	06800	SPEECH PATHOLOGY	909	939	0	193	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,751	14,247	0	2,935	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,048	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,499	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,662	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	781	1,021	0	210	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,112	17,468	0	3,598	0	90.00
90.01	09001	CLINIC - DIABETES	96	1,526	0	314	0	90.01
91.00	09100	EMERGENCY	42,411	14,028	0	2,889	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	433,249	219,277	17,797	43,632	94,568	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	402	2,739	0	564	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,263	109,610	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	466	6,080	0	1,252	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	1,740	15,836	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	438,120	353,542	17,797	45,448	94,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	41,485					11.00
13.00	01300	NURSING ADMINISTRATION	2,533	140,928				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	325	0	101,190			14.00
15.00	01500	PHARMACY	1,572	0	3,156	48,964		15.00
17.00	01700	SOCIAL SERVICE	122	0	0	0	4,279	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,183	57,468	7,703	166	3,361	30.00
31.00	03100	INTENSIVE CARE UNIT	3,237	21,822	3,719	118	918	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,311	6,097	21,535	108	0	50.00
51.00	05100	RECOVERY ROOM	724	6,052	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,400	0	4,969	63	0	54.00
56.00	05600	RADIOISOTOPE	259	0	55	3	0	56.00
57.00	05700	CT SCAN	1,194	0	320	6	0	57.00
58.00	05800	MRI	646	0	17	0	0	58.00
60.00	06000	LABORATORY	3,322	119	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,308	30	14,170	12	0	65.00
66.00	06600	PHYSICAL THERAPY	1,708	0	25	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	710	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	169	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	825	3,367	578	9	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	22,589	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,534	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	47,909	0	73.00
76.97	07697	CARDIAC REHABILITATION	122	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,395	12,446	1,608	132	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,559	33,467	4,211	438	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,624	140,868	101,189	48,964	4,279	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	122	30	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44	0	1	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	695	30	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,485	140,928	101,190	48,964	4,279	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	408,701	0	408,701		30.00
31.00	03100	INTENSIVE CARE UNIT	126,283	0	126,283		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	282,822	0	282,822		50.00
51.00	05100	RECOVERY ROOM	12,510	0	12,510		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,589	0	126,589		54.00
56.00	05600	RADIOISOTOPE	2,555	0	2,555		56.00
57.00	05700	CT SCAN	28,503	0	28,503		57.00
58.00	05800	MRI	27,167	0	27,167		58.00
60.00	06000	LABORATORY	135,261	0	135,261		60.00
65.00	06500	RESPIRATORY THERAPY	77,004	0	77,004		65.00
66.00	06600	PHYSICAL THERAPY	60,192	0	60,192		66.00
67.00	06700	OCCUPATIONAL THERAPY	27,429	0	27,429		67.00
68.00	06800	SPEECH PATHOLOGY	8,111	0	8,111		68.00
69.00	06900	ELECTROCARDIOLOGY	120,937	0	120,937		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,637	0	24,637		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,033	0	18,033		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,571	0	148,571		73.00
76.97	07697	CARDIAC REHABILITATION	8,545	0	8,545		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	159,368	0	159,368		90.00
90.01	09001	CLINIC - DIABETES	11,479	0	11,479		90.01
91.00	09100	EMERGENCY	191,999	0	191,999		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,006,696	0	2,006,696		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,990	0	20,990		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	288,144	0	288,144		192.00
194.00	07950	OCCUPATIONAL HEALTH	45,807	0	45,807		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	43,818	0	43,818		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,405,455	0	2,405,455		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	167,527					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		123,555				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	526	526	22,071,532			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,540	24,540	974,880	-15,858,733	51,545,192	5.00
7.00	00700	OPERATION OF PLANT	18,537	18,537	796,630	0	2,655,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	161,207	8.00
9.00	00900	HOUSEKEEPING	1,815	1,815	430,733	0	907,371	9.00
10.00	01000	DIETARY	4,129	4,129	304,879	0	774,725	10.00
11.00	01100	CAFETERIA	1,858	1,858	72,561	0	225,994	11.00
13.00	01300	NURSING ADMINISTRATION	5,620	5,620	1,340,893	0	2,147,072	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,466	4,466	69,339	0	683,954	14.00
15.00	01500	PHARMACY	1,267	1,267	806,293	0	1,992,202	15.00
17.00	01700	SOCIAL SERVICE	173	173	42,591	0	53,855	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,932	8,932	4,184,562	0	6,086,742	30.00
31.00	03100	INTENSIVE CARE UNIT	2,341	2,341	1,865,854	0	2,559,433	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,038	11,038	1,537,281	0	2,031,124	50.00
51.00	05100	RECOVERY ROOM	0	0	519,526	0	648,616	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,925	4,925	1,070,899	0	1,636,679	54.00
56.00	05600	RADIOISOTOPE	0	0	98,848	0	258,327	56.00
57.00	05700	CT SCAN	1,011	1,011	415,169	0	623,007	57.00
58.00	05800	MRI	1,073	1,073	241,678	0	420,124	58.00
60.00	06000	LABORATORY	4,644	4,644	305,024	0	3,868,274	60.00
65.00	06500	RESPIRATORY THERAPY	2,164	2,164	1,286,400	0	1,634,418	65.00
66.00	06600	PHYSICAL THERAPY	2,297	2,297	681,142	0	1,093,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,058	1,058	372,509	0	476,426	67.00
68.00	06800	SPEECH PATHOLOGY	329	329	78,574	0	106,940	68.00
69.00	06900	ELECTROCARDIOLOGY	4,994	4,994	353,149	0	1,147,205	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	240,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	176,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,844,529	73.00
76.97	07697	CARDIAC REHABILITATION	358	358	62,301	0	91,826	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,123	6,123	934,159	0	1,424,897	90.00
90.01	09001	CLINIC - DIABETES	535	535	1,110	0	11,306	90.01
91.00	09100	EMERGENCY	4,917	4,917	3,045,700	0	4,989,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,464	120,464	21,892,684	-15,858,733	50,972,199	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	960	24,202	0	47,277	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,421	0	19,423	0	266,180	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,131	2,131	251	0	54,829	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	134,972	0	204,707	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	768,366	1,637,089	4,238,727		15,858,733	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.586520	13.249881	0.192045		0.307667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,382		438,120	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000425		0.008500	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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	123,924					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	7,559				8.00
9.00	00900	HOUSEKEEPING	1,815	0	77,343			9.00
10.00	01000	DIETARY	4,129	0	4,129	7,559		10.00
11.00	01100	CAFETERIA	1,858	0	1,858	0	23,388	11.00
13.00	01300	NURSING ADMINISTRATION	5,620	0	5,620	0	1,428	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,466	0	4,466	0	183	14.00
15.00	01500	PHARMACY	1,267	0	1,267	0	886	15.00
17.00	01700	SOCIAL SERVICE	173	0	173	0	69	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,932	5,937	8,932	5,937	4,614	30.00
31.00	03100	INTENSIVE CARE UNIT	2,341	1,622	2,341	1,622	1,825	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,038	0	11,038	0	1,303	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	408	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,925	0	4,925	0	1,353	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	146	56.00
57.00	05700	CT SCAN	1,011	0	1,011	0	673	57.00
58.00	05800	MRI	1,073	0	1,073	0	364	58.00
60.00	06000	LABORATORY	4,644	0	4,644	0	1,873	60.00
65.00	06500	RESPIRATORY THERAPY	2,164	0	2,164	0	1,301	65.00
66.00	06600	PHYSICAL THERAPY	2,297	0	2,297	0	963	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,058	0	1,058	0	400	67.00
68.00	06800	SPEECH PATHOLOGY	329	0	329	0	95	68.00
69.00	06900	ELECTROCARDIOLOGY	4,994	0	4,994	0	465	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	358	0	358	0	69	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,123	0	6,123	0	1,350	90.00
90.01	09001	CLINIC - DIABETES	535	0	535	0	0	90.01
91.00	09100	EMERGENCY	4,917	0	4,917	0	3,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,861	7,559	74,252	7,559	22,902	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	960	0	960	0	69	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,421	0	0	0	25	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,131	0	2,131	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	5,551	0	0	0	392	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	3,472,289	233,052	1,237,394	1,194,834	377,311	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.019504	30.831062	15.998785	158.067734	16.132675	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	353,542	17,797	45,448	94,568	41,485	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.852894	2.354412	0.587616	12.510650	1.773773	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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 1:13 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,500					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,079,320				14.00
15.00	01500	PHARMACY	0	33,661	12,105,177			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,559		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,874	82,163	40,977	5,937		30.00
31.00	03100	INTENSIVE CARE UNIT	1,471	39,673	29,103	1,622		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	411	229,701	26,647	0		50.00
51.00	05100	RECOVERY ROOM	408	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,998	15,617	0		54.00
56.00	05600	RADIOISOTOPE	0	586	731	0		56.00
57.00	05700	CT SCAN	0	3,409	1,488	0		57.00
58.00	05800	MRI	0	181	90	0		58.00
60.00	06000	LABORATORY	8	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	2	151,142	2,953	0		65.00
66.00	06600	PHYSICAL THERAPY	0	270	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	227	6,160	2,141	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	240,937	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	176,355	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,844,528	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	839	17,151	32,575	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	2,256	44,918	108,327	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,496	1,079,305	12,105,177	7,559		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15	0	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	2	0	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
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)	3,078,075	1,093,922	2,709,318	79,152		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	324.007895	1.013529	0.223815	10.471226		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	140,928	101,190	48,964	4,279		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.834526	0.093753	0.004045	0.566080		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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		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	10,958,351		10,958,351	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,326,093		4,326,093	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,534,868		3,534,868	0	0	50.00
51.00	05100	RECOVERY ROOM	986,951		986,951	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,436,059		2,436,059	0	0	54.00
56.00	05600	RADIOISOTOPE	340,919		340,919	0	0	56.00
57.00	05700	CT SCAN	873,834		873,834	0	0	57.00
58.00	05800	MRI	602,689		602,689	0	0	58.00
60.00	06000	LABORATORY	5,295,644		5,295,644	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,408,014	0	2,408,014	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,547,161	0	1,547,161	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	676,032	0	676,032	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	155,857	0	155,857	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,807,763		1,807,763	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	559,261		559,261	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	409,356		409,356	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,139,659		18,139,659	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	136,950		136,950	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,451,111		2,451,111	0	0	90.00
90.01	09001	CLINIC - DIABETES	38,333		38,333	0	0	90.01
91.00	09100	EMERGENCY	7,592,449		7,592,449	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,836,082		1,836,082		0	92.00
200.00		Subtotal (see instructions)	67,113,436	0	67,113,436	0	0	200.00
201.00		Less Observation Beds	1,836,082		1,836,082		0	201.00
202.00		Total (see instructions)	65,277,354	0	65,277,354	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: 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	16,095,941		16,095,941			30.00
31.00	03100	INTENSIVE CARE UNIT	11,358,370		11,358,370			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,853,251	22,970,509	25,823,760	0.136884	0.000000	50.00
51.00	05100	RECOVERY ROOM	187,516	5,616,156	5,803,672	0.170056	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,131,202	15,102,825	16,234,027	0.150059	0.000000	54.00
56.00	05600	RADIOISOTOPE	173,875	3,468,143	3,642,018	0.093607	0.000000	56.00
57.00	05700	CT SCAN	1,024,028	10,395,502	11,419,530	0.076521	0.000000	57.00
58.00	05800	MRI	267,937	2,926,420	3,194,357	0.188673	0.000000	58.00
60.00	06000	LABORATORY	5,342,113	19,708,771	25,050,884	0.211395	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,348,930	4,257,372	8,606,302	0.279797	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	566,039	2,934,853	3,500,892	0.441933	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	519,878	1,093,087	1,612,965	0.419124	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	104,726	397,302	502,028	0.310455	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,399,143	11,219,570	12,618,713	0.143260	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	716,279	2,157,486	2,873,765	0.194609	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,854	1,042,222	1,089,076	0.375875	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,804,940	68,898,451	85,703,391	0.211656	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,299,460	1,299,460	0.105390	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	448	14,403,463	14,403,911	0.170170	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	4,526	4,526	8.469510	0.000000	90.01
91.00	09100	EMERGENCY	1,739,254	46,730,606	48,469,860	0.156643	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,354	6,479,325	6,520,679	0.281578	0.000000	92.00
200.00		Subtotal (see instructions)	64,722,078	241,106,049	305,828,127			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	64,722,078	241,106,049	305,828,127			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
51.00	05100	RECOVERY ROOM	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.000000
65.00	06500	RESPIRATORY THERAPY	0.000000
66.00	06600	PHYSICAL THERAPY	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000
76.97	07697	CARDIAC REHABILITATION	0.000000
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
90.01	09001	CLINIC - DIABETES	0.000000
91.00	09100	EMERGENCY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

		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	10,958,351		10,958,351	0	10,958,351	30.00
31.00	03100	INTENSIVE CARE UNIT	4,326,093		4,326,093	0	4,326,093	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,534,868		3,534,868	0	3,534,868	50.00
51.00	05100	RECOVERY ROOM	986,951		986,951	0	986,951	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,436,059		2,436,059	0	2,436,059	54.00
56.00	05600	RADIOISOTOPE	340,919		340,919	0	340,919	56.00
57.00	05700	CT SCAN	873,834		873,834	0	873,834	57.00
58.00	05800	MRI	602,689		602,689	0	602,689	58.00
60.00	06000	LABORATORY	5,295,644		5,295,644	0	5,295,644	60.00
65.00	06500	RESPIRATORY THERAPY	2,408,014	0	2,408,014	0	2,408,014	65.00
66.00	06600	PHYSICAL THERAPY	1,547,161	0	1,547,161	0	1,547,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	676,032	0	676,032	0	676,032	67.00
68.00	06800	SPEECH PATHOLOGY	155,857	0	155,857	0	155,857	68.00
69.00	06900	ELECTROCARDIOLOGY	1,807,763		1,807,763	0	1,807,763	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	559,261		559,261	0	559,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	409,356		409,356	0	409,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,139,659		18,139,659	0	18,139,659	73.00
76.97	07697	CARDIAC REHABILITATION	136,950		136,950	0	136,950	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,451,111		2,451,111	0	2,451,111	90.00
90.01	09001	CLINIC - DIABETES	38,333		38,333	0	38,333	90.01
91.00	09100	EMERGENCY	7,592,449		7,592,449	0	7,592,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,836,082		1,836,082		1,836,082	92.00
200.00		Subtotal (see instructions)	67,113,436	0	67,113,436	0	67,113,436	200.00
201.00		Less Observation Beds	1,836,082		1,836,082		1,836,082	201.00
202.00		Total (see instructions)	65,277,354	0	65,277,354	0	65,277,354	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: 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	16,095,941		16,095,941			30.00
31.00	03100	INTENSIVE CARE UNIT	11,358,370		11,358,370			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,853,251	22,970,509	25,823,760	0.136884	0.000000	50.00
51.00	05100	RECOVERY ROOM	187,516	5,616,156	5,803,672	0.170056	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,131,202	15,102,825	16,234,027	0.150059	0.000000	54.00
56.00	05600	RADIOISOTOPE	173,875	3,468,143	3,642,018	0.093607	0.000000	56.00
57.00	05700	CT SCAN	1,024,028	10,395,502	11,419,530	0.076521	0.000000	57.00
58.00	05800	MRI	267,937	2,926,420	3,194,357	0.188673	0.000000	58.00
60.00	06000	LABORATORY	5,342,113	19,708,771	25,050,884	0.211395	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,348,930	4,257,372	8,606,302	0.279797	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	566,039	2,934,853	3,500,892	0.441933	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	519,878	1,093,087	1,612,965	0.419124	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	104,726	397,302	502,028	0.310455	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,399,143	11,219,570	12,618,713	0.143260	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	716,279	2,157,486	2,873,765	0.194609	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,854	1,042,222	1,089,076	0.375875	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,804,940	68,898,451	85,703,391	0.211656	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,299,460	1,299,460	0.105390	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	448	14,403,463	14,403,911	0.170170	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	4,526	4,526	8.469510	0.000000	90.01
91.00	09100	EMERGENCY	1,739,254	46,730,606	48,469,860	0.156643	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,354	6,479,325	6,520,679	0.281578	0.000000	92.00
200.00		Subtotal (see instructions)	64,722,078	241,106,049	305,828,127			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	64,722,078	241,106,049	305,828,127			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - DIABETES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	282,822	25,823,760	0.010952	924,611	10,126	50.00
51.00	05100	RECOVERY ROOM	12,510	5,803,672	0.002156	56,177	121	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,589	16,234,027	0.007798	443,730	3,460	54.00
56.00	05600	RADIOISOTOPE	2,555	3,642,018	0.000702	55,502	39	56.00
57.00	05700	CT SCAN	28,503	11,419,530	0.002496	270,590	675	57.00
58.00	05800	MRI	27,167	3,194,357	0.008505	109,988	935	58.00
60.00	06000	LABORATORY	135,261	25,050,884	0.005399	2,004,733	10,824	60.00
65.00	06500	RESPIRATORY THERAPY	77,004	8,606,302	0.008947	1,553,695	13,901	65.00
66.00	06600	PHYSICAL THERAPY	60,192	3,500,892	0.017193	275,104	4,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,429	1,612,965	0.017005	241,998	4,115	67.00
68.00	06800	SPEECH PATHOLOGY	8,111	502,028	0.016156	53,514	865	68.00
69.00	06900	ELECTROCARDIOLOGY	120,937	12,618,713	0.009584	678,500	6,503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,637	2,873,765	0.008573	272,608	2,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,033	1,089,076	0.016558	3,541	59	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,571	85,703,391	0.001734	5,948,797	10,315	73.00
76.97	07697	CARDIAC REHABILITATION	8,545	1,299,460	0.006576	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	159,368	14,403,911	0.011064	0	0	90.00
90.01	09001	CLINIC - DIABETES	11,479	4,526	2.536235	0	0	90.01
91.00	09100	EMERGENCY	191,999	48,469,860	0.003961	84,145	333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,479	6,520,679	0.010502	2,655	28	92.00
200.00		Total (lines 50 through 199)	1,540,191	278,373,816		12,979,888	69,366	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	25,823,760	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,803,672	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,234,027	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,642,018	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	11,419,530	0.000000	57.00
58.00	05800	MRI	0	0	0	3,194,357	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,050,884	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,606,302	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,500,892	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,612,965	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	502,028	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,618,713	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,873,765	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,089,076	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	85,703,391	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,299,460	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	14,403,911	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	4,526	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	48,469,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,520,679	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	278,373,816		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	924,611	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	56,177	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	443,730	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	55,502	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	270,590	0	0	0	57.00
58.00	05800	MRI	0.000000	109,988	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	2,004,733	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,553,695	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	275,104	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	241,998	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	53,514	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	678,500	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	272,608	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,541	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,948,797	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	84,145	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,655	0	0	0	92.00
200.00		Total (lines 50 through 199)		12,979,888	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		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	0.136884	0	4,345,916	0	0	50.00
51.00	05100	RECOVERY ROOM	0.170056	0	1,129,895	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150059	0	3,312,889	0	0	54.00
56.00	05600	RADIOISOTOPE	0.093607	0	1,206,010	0	0	56.00
57.00	05700	CT SCAN	0.076521	0	3,303,988	0	0	57.00
58.00	05800	MRI	0.188673	0	760,437	0	0	58.00
60.00	06000	LABORATORY	0.211395	0	5,071,248	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.279797	0	1,281,446	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441933	0	768,600	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.419124	0	306,801	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.310455	0	72,217	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143260	0	2,922,227	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194609	0	338,308	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375875	0	238,124	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211656	0	26,860,323	3,866	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.105390	0	597,555	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.170170	0	4,801,424	658	0	90.00
90.01	09001	CLINIC - DIABETES	8.469510	0	111	0	0	90.01
91.00	09100	EMERGENCY	0.156643	0	11,497,883	329	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.281578	0	2,014,413	1,769	0	92.00
200.00		Subtotal (see instructions)		0	70,829,815	6,622	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	70,829,815	6,622	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	594,886	0		50.00
51.00	05100	RECOVERY ROOM	192,145	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,129	0		54.00
56.00	05600	RADIOISOTOPE	112,891	0		56.00
57.00	05700	CT SCAN	252,824	0		57.00
58.00	05800	MRI	143,474	0		58.00
60.00	06000	LABORATORY	1,072,036	0		60.00
65.00	06500	RESPIRATORY THERAPY	358,545	0		65.00
66.00	06600	PHYSICAL THERAPY	339,670	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	128,588	0		67.00
68.00	06800	SPEECH PATHOLOGY	22,420	0		68.00
69.00	06900	ELECTROCARDIOLOGY	418,638	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	65,838	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,505	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,685,149	818		73.00
76.97	07697	CARDIAC REHABILITATION	62,976	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	817,058	112		90.00
90.01	09001	CLINIC - DIABETES	940	0		90.01
91.00	09100	EMERGENCY	1,801,063	52		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	567,214	498		92.00
200.00		Subtotal (see instructions)	13,222,989	1,480		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,222,989	1,480		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,133	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,132	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)	5,937	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	1	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)	2,551	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,958,351	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)	231	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)	231	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,958,120	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,958,120	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)	1,536.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,919,535	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)	3,919,535	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,326,093	1,622	2,667.14	664	1,770,981	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,772,098	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,462,614	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,195	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,536.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,836,082	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	408,701	10,958,351	0.037296	1,836,082	68,479	90.00
91.00	Nursing Program cost	0	10,958,351	0.000000	1,836,082	0	91.00
92.00	Allied health cost	0	10,958,351	0.000000	1,836,082	0	92.00
93.00	All other Medical Education	0	10,958,351	0.000000	1,836,082	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,133	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,132	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)	5,937	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	1	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)	127	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,958,351	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)	231	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)	231	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,958,120	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,958,120	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)	1,536.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	195,132	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)	195,132	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,326,093	1,622	2,667.14	30	80,014	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	166,768	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	441,914	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,195	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,536.47	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,836,082	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	408,701	10,958,351	0.037296	1,836,082	68,479	90.00
91.00	Nursing Program cost	0	10,958,351	0.000000	1,836,082	0	91.00
92.00	Allied health cost	0	10,958,351	0.000000	1,836,082	0	92.00
93.00	All other Medical Education	0	10,958,351	0.000000	1,836,082	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,642,542		30.00
31.00	03100	INTENSIVE CARE UNIT		4,323,363		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136884	924,611	126,564	50.00
51.00	05100	RECOVERY ROOM	0.170056	56,177	9,553	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150059	443,730	66,586	54.00
56.00	05600	RADIOISOTOPE	0.093607	55,502	5,195	56.00
57.00	05700	CT SCAN	0.076521	270,590	20,706	57.00
58.00	05800	MRI	0.188673	109,988	20,752	58.00
60.00	06000	LABORATORY	0.211395	2,004,733	423,791	60.00
65.00	06500	RESPIRATORY THERAPY	0.279797	1,553,695	434,719	65.00
66.00	06600	PHYSICAL THERAPY	0.441933	275,104	121,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.419124	241,998	101,427	67.00
68.00	06800	SPEECH PATHOLOGY	0.310455	53,514	16,614	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143260	678,500	97,202	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194609	272,608	53,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375875	3,541	1,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211656	5,948,797	1,259,099	73.00
76.97	07697	CARDIAC REHABILITATION	0.105390	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.170170	0	0	90.00
90.01	09001	CLINIC - DIABETES	8.469510	0	0	90.01
91.00	09100	EMERGENCY	0.156643	84,145	13,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.281578	2,655	748	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,979,888	2,772,098	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)		12,979,888		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136884	0	0	50.00
51.00	05100	RECOVERY ROOM	0.170056	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150059	0	0	54.00
56.00	05600	RADIOISOTOPE	0.093607	0	0	56.00
57.00	05700	CT SCAN	0.076521	0	0	57.00
58.00	05800	MRI	0.188673	0	0	58.00
60.00	06000	LABORATORY	0.211395	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.279797	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441933	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.419124	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.310455	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143260	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194609	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375875	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211656	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.105390	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.170170	0	0	90.00
90.01	09001	CLINIC - DIABETES	8.469510	0	0	90.01
91.00	09100	EMERGENCY	0.156643	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.281578	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		323,061		30.00
31.00	03100	INTENSIVE CARE UNIT		208,725		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136884	19,599	2,683	50.00
51.00	05100	RECOVERY ROOM	0.170056	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150059	20,197	3,031	54.00
56.00	05600	RADIOISOTOPE	0.093607	0	0	56.00
57.00	05700	CT SCAN	0.076521	54,644	4,181	57.00
58.00	05800	MRI	0.188673	4,317	815	58.00
60.00	06000	LABORATORY	0.211395	125,029	26,431	60.00
65.00	06500	RESPIRATORY THERAPY	0.279797	93,522	26,167	65.00
66.00	06600	PHYSICAL THERAPY	0.441933	5,693	2,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.419124	4,659	1,953	67.00
68.00	06800	SPEECH PATHOLOGY	0.310455	2,969	922	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143260	22,337	3,200	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194609	11,307	2,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375875	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211656	348,415	73,744	73.00
76.97	07697	CARDIAC REHABILITATION	0.105390	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.170170	0	0	90.00
90.01	09001	CLINIC - DIABETES	8.469510	0	0	90.01
91.00	09100	EMERGENCY	0.156643	120,819	18,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.281578	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		833,507	166,768	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)		833,507		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.136884	0	0	50.00
51.00	05100	RECOVERY ROOM	0.170056	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150059	0	0	54.00
56.00	05600	RADIOISOTOPE	0.093607	0	0	56.00
57.00	05700	CT SCAN	0.076521	0	0	57.00
58.00	05800	MRI	0.188673	0	0	58.00
60.00	06000	LABORATORY	0.211395	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.279797	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441933	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.419124	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.310455	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143260	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.194609	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375875	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211656	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.105390	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.170170	0	0	90.00
90.01	09001	CLINIC - DIABETES	8.469510	0	0	90.01
91.00	09100	EMERGENCY	0.156643	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.281578	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 1:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,224,469	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	13,224,469	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)	13,356,714	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	82,238	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	12,462,397	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)	812,079	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)	812,079	30.00
31.00	Primary payer payments	43	31.00
32.00	Subtotal (line 30 minus line 31)	812,036	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)	1,868,722	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	1,214,669	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	702,042	36.00
37.00	Subtotal (see instructions)	2,026,705	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)	2,026,705	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	3,459,631	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-1,432,926	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	722,200	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: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,798,910		3,459,631	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	11/03/2021	295,700		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)		295,700		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)		8,094,610		3,459,631	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		260,596		1,432,926	6.02
7.00	Total Medicare program liability (see instructions)		7,834,014		2,026,705	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 1:13 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	0	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 1:13 pm

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 1:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	8,462,614	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	8,462,614	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	8,547,240	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	8,547,240	19.00
20.00	Deductibles (exclude professional component)	759,428	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	7,787,812	22.00
23.00	Coinsurance	10,017	23.00
24.00	Subtotal (line 22 minus line 23)	7,777,795	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	86,491	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	56,219	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,702	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	7,834,014	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	7,834,014	30.00
30.01	Sequestration adjustment (see instructions)	0	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	8,094,610	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-260,596	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	444,522	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 1:13 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	99,576,138	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	10,680,293	0	0	0	4.00
5.00	Other receivable	975,074	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,081,468	0	0	0	7.00
8.00	Prepaid expenses	211,115	0	0	0	8.00
9.00	Other current assets	0	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)	113,524,088	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	931,334	0	0	0	12.00
13.00	Land improvements	1,119,735	0	0	0	13.00
14.00	Accumulated depreciation	-1,085,466	0	0	0	14.00
15.00	Buildings	19,882,107	0	0	0	15.00
16.00	Accumulated depreciation	-13,533,543	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	242,498	0	0	0	21.00
22.00	Accumulated depreciation	-223,460	0	0	0	22.00
23.00	Major movable equipment	15,895,588	0	0	0	23.00
24.00	Accumulated depreciation	-12,030,881	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	5,206,014	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,403,926	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,170,605	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,170,605	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	134,098,619	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,803,966	0	0	0	37.00
38.00	Salaries, wages, and fees payable	291,965	0	0	0	38.00
39.00	Payroll taxes payable	1,217,360	0	0	0	39.00
40.00	Notes and loans payable (short term)	59,503	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	2,525,142				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,935,259	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,833,195	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	238,718	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	238,718	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,071,913	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	118,026,706				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)	118,026,706	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	134,098,619	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 1:13 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		88,442,820		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		29,489,382				2.00
3.00	Total (sum of line 1 and line 2)		117,932,202		0		3.00
4.00	DONATED PPE	94,500		0		0	4.00
5.00	ROUNDING	4		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)		94,504		0		10.00
11.00	Subtotal (line 3 plus line 10)		118,026,706		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		118,026,706		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	DONATED PPE		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 1:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,087,372		16,087,372	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	8,569		8,569	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,095,941		16,095,941	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,358,370		11,358,370	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,358,370		11,358,370	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,454,311		27,454,311	17.00
18.00	Ancillary services	35,486,711	173,488,127	208,974,838	18.00
19.00	Outpatient services	1,781,056	67,617,920	69,398,976	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	PHYSICIAN REVENUE	0	1,981,487	1,981,487	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	64,722,078	243,087,534	307,809,612	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		68,897,523		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)		68,897,523		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-3 | Date/Time Prepared: 5/26/2022 1:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	307,809,612	1.00
2.00	Less contractual allowances and discounts on patients' accounts	219,868,094	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,941,518	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	68,897,523	4.00
5.00	Net income from service to patients (line 3 minus line 4)	19,043,995	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,910,820	24.00
24.50	COVID-19 PHE Funding	8,534,567	24.50
25.00	Total other income (sum of lines 6-24)	10,445,387	25.00
26.00	Total (line 5 plus line 25)	29,489,382	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	29,489,382	29.00