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: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 2:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 2:03 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 IU HEALTH TIPTON HOSPITAL (15-1311) 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	Cara Breidster		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	Cara Breidster			2
3	Signatory Title	CFO			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	-1,120,263	-1,878,611	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	5,339	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-1,114,924	-1,878,611	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 2:03 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	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	IU HEALTH TIPTON HOSPITAL	151311	99915	1	11/12/2005	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 TIPTON HOSPITAL	15Z311	29020		11/12/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2021	12/31/2021	20.00
21.00	Type of Control (see instructions)	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	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 2:03 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.				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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 2:03 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 2:03 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 2:03 pm

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	37,379	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 2:03 pm

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	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.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 2:03 pm

		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	36	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 2:03 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		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	04/04/2022	Y	04/04/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 2:03 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.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 2:03 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 OF GOVERNMENT PROGRAMS		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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 2:03 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	25	9,125	62,400.00	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)		25	9,125	62,400.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	62,400.00	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 2:03 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)	1,172	3	2,592			1.00
2.00	HMO and other (see instructions)	806	185				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	74	0	74			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,246	3	2,668			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)	1,246	3	2,668	0.00	175.19	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)			8			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	175.19	27.00
28.00	Observation Bed Days		0	311			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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 2:03 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	320	1	673	1.00
2.00	HMO and other (see instructions)			178	46		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	320	1	673	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 2:03 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)	0.270586	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,813,981	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	27,703,116	6.00
7.00	Medicaid cost (line 1 times line 6)	7,496,075	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)	3,682,094	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)	2,786	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	35,601	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	9,633	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)	6,847	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)	3,688,941	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,684,892	257,963	1,942,855	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	455,908	257,963	713,871	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)	455,908	257,963	713,871	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,127,820	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,002,223	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,541,881	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,585,939	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	968,791	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,682,662	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,371,603	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 2:03 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	907,564	907,564	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		0	0	611,654	611,654	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,012,932	1,012,932	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	98	8,860	8,958	2,320,815	2,329,773	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	669,535	9,109,696	9,779,231	-1,442,829	8,336,402	5.00
7.00	00700	OPERATION OF PLANT	645,112	3,206,823	3,851,935	-217,666	3,634,269	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	13,984	105,759	119,743	-3,437	116,306	8.00
9.00	00900	HOUSEKEEPING	399,131	339,154	738,285	-118,019	620,266	9.00
10.00	01000	DIETARY	401,931	520,772	922,703	-575,415	347,288	10.00
11.00	01100	CAFETERIA	0	0	0	467,440	467,440	11.00
13.00	01300	NURSING ADMINISTRATION	1,141,688	399,680	1,541,368	-853,748	687,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,898	3,898	540,117	544,015	14.00
15.00	01500	PHARMACY	757,444	5,768,749	6,526,193	-5,342,323	1,183,870	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,141,416	1,228,315	3,369,731	-140,013	3,229,718	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,288,461	3,461,061	4,749,522	-2,461,869	2,287,653	50.00
53.00	05300	ANESTHESIOLOGY	106,300	320,694	426,994	-13,048	413,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,470	911,846	2,056,316	-581,329	1,474,987	54.00
60.00	06000	LABORATORY	8,657	1,500,435	1,509,092	-21,630	1,487,462	60.00
65.00	06500	RESPIRATORY THERAPY	609,363	228,821	838,184	-72,347	765,837	65.00
66.00	06600	PHYSICAL THERAPY	776,153	506,654	1,282,807	-481,371	801,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,069	50,851	231,920	16,069	247,989	67.00
68.00	06800	SPEECH PATHOLOGY	24,404	4,455	28,859	235	29,094	68.00
69.00	06900	ELECTROCARDIOLOGY	523,430	280,877	804,307	-135,271	669,036	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	324,735	324,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,275,247	1,275,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,570,759	4,570,759	73.00
73.01	03480	ONCOLOGY	261,232	90,457	351,689	-66,420	285,269	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	824,302	824,302	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	102,299	56,762	159,061	-48,586	110,475	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,218,775	1,745,267	2,964,042	-143,011	2,821,031	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)	12,414,952	29,849,886	42,264,838	153,537	42,418,375	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102,300	141,712	244,012	-122,441	121,571	192.00
192.01	19201	OCCUPATIONAL MEDICINE	78,194	69,963	148,157	-31,096	117,061	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	12,595,446	30,061,561	42,657,007	0	42,657,007	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 2:03 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	755,164	1,662,728		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	-373,546	238,108		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	253,862	1,266,794		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,664	2,321,109		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-754,709	7,581,693		5.00
7.00	00700	OPERATION OF PLANT	15,633	3,649,902		7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	116,306		8.00
9.00	00900	HOUSEKEEPING	-57,304	562,962		9.00
10.00	01000	DIETARY	417	347,705		10.00
11.00	01100	CAFETERIA	-23,844	443,596		11.00
13.00	01300	NURSING ADMINISTRATION	45,951	733,571		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	544,015		14.00
15.00	01500	PHARMACY	-36,688	1,147,182		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-474,952	2,754,766		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-314,067	1,973,586		50.00
53.00	05300	ANESTHESIOLOGY	-363,594	50,352		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-186,953	1,288,034		54.00
60.00	06000	LABORATORY	0	1,487,462		60.00
65.00	06500	RESPIRATORY THERAPY	0	765,837		65.00
66.00	06600	PHYSICAL THERAPY	0	801,436		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,989		67.00
68.00	06800	SPEECH PATHOLOGY	0	29,094		68.00
69.00	06900	ELECTROCARDIOLOGY	-113,543	555,493		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	324,735		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,275,247		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,570,759		73.00
73.01	03480	ONCOLOGY	0	285,269		73.01
73.02	07301	BLOOD DISORDER DRUGS	0	824,302		73.02
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	110,475		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-936,053	1,884,978		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)	-2,572,890	39,845,485		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	121,571		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	117,061		192.01
192.02	19202	VACANT SPACE	0	0		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,572,890	40,084,117		200.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 2:03 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	572,725		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,010,879		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
	0		0	1,583,604		
	B - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	611,654		1.00
2.00		0.00	0	0		2.00
	0		0	611,654		
	D - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,256,813		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
	0		0	2,256,813		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	233,884	233,556		1.00
	0		233,884	233,556		
	F - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	540,157		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	324,735		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,275,247		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	212		5.00
6.00	OPERATION OF PLANT	7.00	0	423		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	7		7.00
8.00	HOUSEKEEPING	9.00	0	119		8.00
9.00	DIETARY	10.00	0	28		9.00
10.00	ANESTHESIOLOGY	53.00	0	43		10.00
11.00	SPEECH PATHOLOGY	68.00	0	1		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	2,140,988		
	G - DRUGS					
1.00	PHARMACY	15.00	0	95,092		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,395,061		2.00
3.00	ANESTHESIOLOGY	53.00	0	724		3.00
4.00		0.00	0	0		4.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 2:03 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	0		0	5,490,877		
	H - ORTHOPEDIC CLERICAL STAFF					
1.00	OCCUPATIONAL THERAPY	67.00	46,662	0		1.00
2.00	SPEECH PATHOLOGY	68.00	1,994	0		2.00
	0		48,656	0		
	J - MAINTENANCE & LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	275,798		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,651		2.00
3.00	OPERATION OF PLANT	7.00	0	7,348		3.00
	0		0	284,797		
	L - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59,041		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,053		2.00
	0		0	61,094		
	M - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	63,986	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	15,771	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	5,686	0		3.00
4.00	NURSING ADMINISTRATION	13.00	10,318	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	849	0		5.00
6.00	OCCUPATIONAL THERAPY	67.00	5,457	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	4,612	0		7.00
8.00	OCCUPATIONAL MEDICINE	192.01	985	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
	0		107,664	0		
	N - INFUSION DRUGS					
1.00	BLOOD DISORDER DRUGS	73.02	0	824,302		1.00
	TOTALS		0	824,302		
	P - SURGE PREMIUM WAGES					
1.00	ADULTS & PEDIATRICS	30.00	298,304	22,743		1.00
2.00	OPERATING ROOM	50.00	28,558	2,177		2.00
3.00	RESPIRATORY THERAPY	65.00	83,541	6,369		3.00
4.00	EMERGENCY	91.00	177,736	13,550		4.00
	TOTALS		588,139	44,839		
500.00	Grand Total: Increases		978,343	13,532,524		500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 2:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	702,385	9		1.00
2.00	OPERATION OF PLANT	7.00	0	34,742	9		2.00
3.00	DIETARY	10.00	0	7,629	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	69,876	0		4.00
5.00	PHARMACY	15.00	0	23,991	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	40,171	0		6.00
7.00	OPERATING ROOM	50.00	0	281,453	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	8,988	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	227,342	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	8,269	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	56,988	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	44,024	0		12.00
13.00	ONCOLOGY	73.01	0	676	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	14,177	0		14.00
15.00	EMERGENCY	91.00	0	23,653	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	39,240	0		16.00
	0		0	1,583,604			
	B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	611,048	11		1.00
2.00	OPERATION OF PLANT	7.00	0	606	0		2.00
	0		0	611,654			
	D - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	85,936	0		1.00
2.00	OPERATION OF PLANT	7.00	0	147,967	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	9,130	0		3.00
4.00	HOUSEKEEPING	9.00	0	108,250	0		4.00
5.00	DIETARY	10.00	0	99,063	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	152,663	0		6.00
7.00	PHARMACY	15.00	0	109,717	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	330,372	0		8.00
9.00	OPERATING ROOM	50.00	0	246,195	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	4,827	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	253,561	0		11.00
12.00	LABORATORY	60.00	0	324	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	114,731	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	171,186	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	36,004	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	1,760	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	66,230	0		17.00
18.00	ONCOLOGY	73.01	0	41,415	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	31,550	0		19.00
20.00	EMERGENCY	91.00	0	191,994	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	35,754	0		21.00
22.00	OCCUPATIONAL MEDICINE	192.01	0	18,184	0		22.00
	0		0	2,256,813			
	E - CAFETERIA						
1.00	DIETARY	10.00	233,884	233,556	0		1.00
	0		233,884	233,556			
	F - MEDICAL SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	8,549	0		1.00
2.00	PHARMACY	15.00	0	26,191	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	57,813	0		3.00
4.00	OPERATING ROOM	50.00	0	1,889,946	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,629	0		5.00
6.00	LABORATORY	60.00	0	21,301	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	36,047	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	5,937	0		8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	46	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	6,045	0		10.00
11.00	ONCOLOGY	73.01	0	7,364	0		11.00
12.00	CARDIAC REHABILITATION	76.97	0	940	0		12.00
13.00	EMERGENCY	91.00	0	57,573	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	282	0		14.00
15.00	OCCUPATIONAL MEDICINE	192.01	0	3,325	0		15.00
	0		0	2,140,988			
	G - DRUGS						
1.00	PHARMACY	15.00	0	5,272,139	0		1.00
2.00	OPERATION OF PLANT	7.00	0	2,515	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	40	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	33,553	0		4.00
5.00	OPERATING ROOM	50.00	0	29,774	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,701	0		6.00
7.00	LABORATORY	60.00	0	5	0		7.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 2:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
8.00	RESPIRATORY THERAPY	65.00	0	959	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	233	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	16,080	0		10.00
11.00	ONCOLOGY	73.01	0	10,216	0		11.00
12.00	CARDIAC REHABILITATION	76.97	0	17	0		12.00
13.00	EMERGENCY	91.00	0	41,070	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3	0		14.00
15.00	OCCUPATIONAL MEDICINE	192.01	0	10,572	0		15.00
	0		0	5,490,877			
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	48,656	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		48,656	0			
	J - MAINTENANCE & LEASE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	35,112	14		1.00
2.00	PHYSICAL THERAPY	66.00	0	197,911	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	51,774	0		3.00
	0		0	284,797			
	L - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,094	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	61,094			
	M - ACCRUED PTO						
1.00	OPERATION OF PLANT	7.00	4,495	0	0		1.00
2.00	HOUSEKEEPING	9.00	9,888	0	0		2.00
3.00	DIETARY	10.00	1,311	0	0		3.00
4.00	PHARMACY	15.00	5,377	0	0		4.00
5.00	OPERATING ROOM	50.00	45,236	0	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	7,096	0	0		6.00
7.00	RESPIRATORY THERAPY	65.00	2,251	0	0		7.00
8.00	PHYSICAL THERAPY	66.00	460	0	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	2,892	0	0		9.00
10.00	ONCOLOGY	73.01	6,749	0	0		10.00
11.00	CARDIAC REHABILITATION	76.97	1,902	0	0		11.00
12.00	EMERGENCY	91.00	20,007	0	0		12.00
	0		107,664	0			
	N - INFUSION DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	824,302	0		1.00
	TOTALS		0	824,302			
	P - SURGE PREMIUM WAGES						
1.00	NURSING ADMINISTRATION	13.00	588,139	44,839	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		588,139	44,839			
500.00	Grand Total: Decreases		978,343	13,532,524			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 2:03 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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,872,457	266,722	0	266,722	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,340,408	542,888	0	542,888	628,512	6.00
7.00	HIT designated Assets	840,651	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,053,516	809,610	0	809,610	628,512	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,053,516	809,610	0	809,610	628,512	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	3,139,179	372,370	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,254,784	5,941,761	6.00
7.00	HIT designated Assets	840,651	840,651	7.00
8.00	Subtotal (sum of lines 1-7)	15,234,614	7,154,782	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,234,614	7,154,782	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2022 2:03 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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
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
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0		1.01
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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2022 2:03 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,979,830	0	3,979,830	0.261236	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,254,784	0	11,254,784	0.738764	0	2.00
3.00	Total (sum of lines 1-2)	15,234,614	0	15,234,614	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,358,465	-30,576	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	-33,785	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,264,741	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,589,421	-30,576	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	59,041	0	275,798	1,662,728	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	271,893	0	0	0	238,108	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,053	0	0	1,266,794	2.00
3.00	Total (sum of lines 1-2)	271,893	61,094	0	275,798	3,167,630	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 2:03 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-339,761	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1.01
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	-2,256,557			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	3,389,323			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-23,844	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	B	-232,458	PHARMACY	15.00	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	A	782,496	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	44,742	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 2:03 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LEASE REVENUE	B	-30,576	CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.01	MISCELLANEOUS INCOME	B	-43,265	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	INVESTMENT FEES	A	8,531	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-57,304	HOUSEKEEPING	9.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	417	DIETARY	10.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-331	NURSING ADMINISTRATION	13.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-3	PHARMACY	15.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-25	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	MISCELLANEOUS INCOME	B	-19,542	ELECTROCARDIOLOGY	69.00	0	33.08
33.09	MEDICAID HOSPITAL ASSESSMENT FEE	A	-1,266,441	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ASSISTED LIVING DEPRECIATION - BLDG	A	-125,777	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	CRNA SALARY EXPENSE	A	-106,300	ANESTHESIOLOGY	53.00	0	33.11
33.12	CRNA BENEFITS EXPENSE	A	-20,647	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	PATIENT PHONES - SALARY	A	-2,904	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	PATIENT PHONES - BENEFITS	A	-564	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	EMPLOYEE BENEFITS	A	-2,256,877	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	RECRUTING	A	8,571	ADULTS & PEDIATRICS	30.00	0	33.16
33.17	LEASE DEPRECIATION - CARRY FORWARD	A	284	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	EQUIPMENT DEPRECIATION - CARRY FORWA	A	9,682	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19	MARKETING	A	-30,760	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	UNWONTED SITUATIONS	A	-3,000	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,572,890				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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 2:03 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 ALLOCATION	360,109	231,372	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	577,263	611,048	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	199,438	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	2,269,424	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6,270,411	5,807,058	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE ALLOCATION	0	24,619	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	180,507	63,730	4.03
4.04	7.00	OPERATION OF PLANT	RELATED PARTY	21,612	5,979	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	57,391	11,109	4.05
4.06	15.00	PHARMACY	RELATED PARTY	195,773	0	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	19,755	7,445	4.07
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	4,368	4,368	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	185,168	185,168	4.09
4.10	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	27,094	27,094	4.10
4.11	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	45,437	45,437	4.11
4.12	14.00	CENTRAL SERVICES & SUPPLY	SHARED EMPLOYEES	73	73	4.12
4.13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	488,591	488,591	4.13
4.14	50.00	OPERATING ROOM	SHARED EMPLOYEES	77,617	77,617	4.14
4.15	53.00	ANESTHESIOLOGY	SHARED EMPLOYEES	100,274	100,274	4.15
4.16	54.00	RADIOLOGY-DIAGNOSTIC	SHARED EMPLOYEES	161,772	161,772	4.16
4.17	60.00	LABORATORY	SHARED EMPLOYEES	1,446,851	1,446,851	4.17
4.18	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	283,062	283,062	4.18
4.19	91.00	EMERGENCY	SHARED EMPLOYEES	1,263,230	1,263,230	4.19
4.20	192.01	OCCUPATIONAL MEDICINE	SHARED EMPLOYEES	28,718	28,718	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,263,938	10,874,615	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	IU HEALTH	100.00	6.00
7.00	F		0.00	IU WEST	100.00	7.00
8.00	F		0.00	IU NORTH	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 2:03 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	128,737	9		1.00
2.00	-33,785	9		2.00
3.00	199,438	9		3.00
4.00	2,269,424	0		4.00
4.01	463,353	0		4.01
4.02	-24,619	0		4.02
4.03	116,777	0		4.03
4.04	15,633	0		4.04
4.05	46,282	0		4.05
4.06	195,773	0		4.06
4.07	12,310	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
5.00	3,389,323			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	HEALTHCARE		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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 2:03 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	480,523	480,523	0	0	0	1.00
2.00	50.00	OPERATING ROOM	314,067	314,067	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	257,294	257,294	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	174,619	174,619	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	94,001	94,001	0	0	0	5.00
6.00	91.00	EMERGENCY	1,263,230	936,053	327,177	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			2,583,734	2,256,557	327,177		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	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	480,523		1.00
2.00	50.00	OPERATING ROOM	0	0	0	314,067		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	257,294		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	174,619		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	94,001		5.00
6.00	91.00	EMERGENCY	0	0	0	936,053		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	2,256,557		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,662,728	1,662,728				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	238,108	0	238,108			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,266,794			1,266,794		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,321,109	7,252	1,186	5,525	2,335,072	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,581,693	103,918	17,000	79,173	128,275	5.00
7.00	00700	OPERATION OF PLANT	3,649,902	410,842	59,036	313,012	120,421	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	116,306	26,899	4,400	20,494	3,697	8.00
9.00	00900	HOUSEKEEPING	562,962	16,064	2,628	12,239	73,168	9.00
10.00	01000	DIETARY	347,705	29,113	4,762	22,180	31,342	10.00
11.00	01100	CAFETERIA	443,596	40,835	6,680	31,111	43,965	11.00
13.00	01300	NURSING ADMINISTRATION	733,571	37,330	6,107	28,441	105,993	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	544,015	34,522	5,647	26,301	0	14.00
15.00	01500	PHARMACY	1,147,182	19,113	3,127	14,562	141,371	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,754,766	164,667	26,937	125,456	458,772	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,973,586	200,972	32,876	153,116	239,065	50.00
53.00	05300	ANESTHESIOLOGY	50,352	3,790	620	2,887	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,288,034	104,151	17,038	79,350	213,799	54.00
60.00	06000	LABORATORY	1,487,462	42,687	6,983	32,522	1,627	60.00
65.00	06500	RESPIRATORY THERAPY	765,837	2,498	409	1,903	129,826	65.00
66.00	06600	PHYSICAL THERAPY	801,436	60,430	3,493	46,040	136,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,989	18,088	1,045	13,781	43,834	67.00
68.00	06800	SPEECH PATHOLOGY	29,094	775	45	591	4,962	68.00
69.00	06900	ELECTROCARDIOLOGY	555,493	27,364	4,476	20,848	97,849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,735	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,275,247	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,570,759	0	0	0	0	73.00
73.01	03480	ONCOLOGY	285,269	16,546	2,707	12,606	47,837	73.01
73.02	07301	BLOOD DISORDER DRUGS	824,302	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	110,475	17,941	2,935	13,669	18,872	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,884,978	116,881	19,120	89,049	258,750	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)	39,845,485	1,502,678	229,257	1,144,856	2,300,091	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	121,571	143,160	6,088	109,070	20,097	192.00
192.01	19201	OCCUPATIONAL MEDICINE	117,061	16,890	2,763	12,868	14,884	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,084,117	1,662,728	238,108	1,266,794	2,335,072	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,910,059	7,910,059				5.00
7.00	00700	OPERATION OF PLANT	4,553,213	1,119,417	5,672,630			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	171,796	42,236	147,110	0	361,142	8.00
9.00	00900	HOUSEKEEPING	667,061	163,998	87,852	0	0	9.00
10.00	01000	DIETARY	435,102	106,971	159,217	0	0	10.00
11.00	01100	CAFETERIA	566,187	139,198	223,327	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	911,442	224,080	204,155	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	610,485	150,089	188,799	0	0	14.00
15.00	01500	PHARMACY	1,325,355	325,841	104,527	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,530,598	868,005	900,563	0	361,142	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,599,615	639,121	1,099,112	0	0	50.00
53.00	05300	ANESTHESIOLOGY	57,649	14,173	20,726	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,702,372	418,532	569,599	0	0	54.00
60.00	06000	LABORATORY	1,571,281	386,303	233,455	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	900,473	221,383	13,661	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,048,065	257,669	116,774	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,737	79,837	34,952	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,467	8,720	1,507	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	706,030	173,579	149,654	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,735	79,837	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,275,247	313,522	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,570,759	1,123,732	0	0	0	73.00
73.01	03480	ONCOLOGY	364,965	89,727	90,490	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	824,302	202,656	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	163,892	40,293	98,121	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,368,778	582,369	639,221	0	0	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)	39,519,665	7,771,288	5,082,822	0	361,142	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	399,986	98,337	497,434	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	164,466	40,434	92,374	0	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,084,117	7,910,059	5,672,630	0	361,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	918,911					9.00
10.00	01000	DIETARY	24,370	725,660				10.00
11.00	01100	CAFETERIA	34,182	0	962,894			11.00
13.00	01300	NURSING ADMINISTRATION	31,248	0	42,040	1,412,965		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,898	0	0	0	978,271	14.00
15.00	01500	PHARMACY	15,999	0	60,118	0	11,968	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	137,840	722,255	212,207	740,286	21,953	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	168,231	0	120,738	291,577	170,536	50.00
53.00	05300	ANESTHESIOLOGY	3,172	0	4,807	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,183	0	105,171	435	9,135	54.00
60.00	06000	LABORATORY	35,733	0	68,727	0	8,952	60.00
65.00	06500	RESPIRATORY THERAPY	2,091	0	49,788	0	16,115	65.00
66.00	06600	PHYSICAL THERAPY	50,585	0	69,803	0	508	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,141	0	23,459	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	649	0	2,152	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,906	0	42,183	39,131	2,856	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	144,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	566,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	13,850	0	21,952	39,962	1,341	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	15,018	0	8,752	33,407	366	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	97,839	3,405	109,403	254,319	22,405	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)	784,935	725,660	941,300	1,399,117	976,634	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	119,837	0	11,550	198	151	192.00
192.01	19201	OCCUPATIONAL MEDICINE	14,139	0	10,044	13,650	1,486	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	918,911	725,660	962,894	1,412,965	978,271	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
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	1,843,808					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,661	7,504,510	0	7,504,510		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,751	5,094,681	0	5,094,681		50.00
53.00	05300	ANESTHESIOLOGY	0	100,527	0	100,527		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,661	2,894,088	0	2,894,088		54.00
60.00	06000	LABORATORY	0	2,304,451	0	2,304,451		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,203,511	0	1,203,511		65.00
66.00	06600	PHYSICAL THERAPY	11	1,543,415	0	1,543,415		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	478,126	0	478,126		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,495	0	48,495		68.00
69.00	06900	ELECTROCARDIOLOGY	286	1,136,625	0	1,136,625		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	548,776	0	548,776		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,155,064	0	2,155,064		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,535,040	7,229,531	0	7,229,531		73.00
73.01	03480	ONCOLOGY	2,937	625,224	0	625,224		73.01
73.02	07301	BLOOD DISORDER DRUGS	276,833	1,303,791	0	1,303,791		73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	2	359,851	0	359,851		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	11,626	4,089,365	0	4,089,365		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)	1,843,808	38,620,031	0	38,620,031		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,127,493	0	1,127,493		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	336,593	0	336,593		192.01
192.02	19202	VACANT SPACE	0	0	0	0		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,843,808	40,084,117	0	40,084,117		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS BLDG & FIXT - INTERES	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,252	1,186	5,525	13,963	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	103,918	17,000	79,173	200,091	5.00
7.00	00700	OPERATION OF PLANT	0	410,842	59,036	313,012	782,890	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,899	4,400	20,494	51,793	8.00
9.00	00900	HOUSEKEEPING	0	16,064	2,628	12,239	30,931	9.00
10.00	01000	DIETARY	0	29,113	4,762	22,180	56,055	10.00
11.00	01100	CAFETERIA	0	40,835	6,680	31,111	78,626	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,330	6,107	28,441	71,878	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,522	5,647	26,301	66,470	14.00
15.00	01500	PHARMACY	0	19,113	3,127	14,562	36,802	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	164,667	26,937	125,456	317,060	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	200,972	32,876	153,116	386,964	50.00
53.00	05300	ANESTHESIOLOGY	0	3,790	620	2,887	7,297	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,151	17,038	79,350	200,539	54.00
60.00	06000	LABORATORY	0	42,687	6,983	32,522	82,192	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,498	409	1,903	4,810	65.00
66.00	06600	PHYSICAL THERAPY	0	60,430	3,493	46,040	109,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,088	1,045	13,781	32,914	67.00
68.00	06800	SPEECH PATHOLOGY	0	775	45	591	1,411	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,364	4,476	20,848	52,688	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
73.01	03480	ONCOLOGY	0	16,546	2,707	12,606	31,859	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	17,941	2,935	13,669	34,545	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	116,881	19,120	89,049	225,050	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	1,502,678	229,257	1,144,856	2,876,791	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	143,160	6,088	109,070	258,318	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	16,890	2,763	12,868	32,521	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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	1,662,728	238,108	1,266,794	3,167,630	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - OFFSITE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,963					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	767	200,858				5.00
7.00	00700	OPERATION OF PLANT	720	28,426	812,036			7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	22	1,073	21,059	0	73,947	8.00
9.00	00900	HOUSEKEEPING	438	4,164	12,576	0	0	9.00
10.00	01000	DIETARY	187	2,716	22,792	0	0	10.00
11.00	01100	CAFETERIA	263	3,535	31,969	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	634	5,690	29,225	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,811	27,027	0	0	14.00
15.00	01500	PHARMACY	845	8,274	14,963	0	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,745	22,042	128,915	0	73,947	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,429	16,229	157,337	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	360	2,967	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,278	10,628	81,538	0	0	54.00
60.00	06000	LABORATORY	10	9,810	33,419	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	776	5,622	1,956	0	0	65.00
66.00	06600	PHYSICAL THERAPY	817	6,543	16,716	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262	2,027	5,003	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30	221	216	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	585	4,408	21,423	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,027	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,961	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,532	0	0	0	73.00
73.01	03480	ONCOLOGY	286	2,278	12,954	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	5,146	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	113	1,023	14,046	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,547	14,788	91,504	0	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)	13,754	197,334	727,605	0	73,947	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	120	2,497	71,208	0	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	89	1,027	13,223	0	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	13,963	200,858	812,036	0	73,947	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	48,109					9.00
10.00	01000	DIETARY	1,276	83,026				10.00
11.00	01100	CAFETERIA	1,790	0	116,183			11.00
13.00	01300	NURSING ADMINISTRATION	1,636	0	5,073	114,136		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,513	0	0	0	98,821	14.00
15.00	01500	PHARMACY	838	0	7,254	0	1,209	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,217	82,636	25,603	59,798	2,218	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,808	0	14,568	23,553	17,227	50.00
53.00	05300	ANESTHESIOLOGY	166	0	580	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,564	0	12,690	35	923	54.00
60.00	06000	LABORATORY	1,871	0	8,293	0	904	60.00
65.00	06500	RESPIRATORY THERAPY	109	0	6,007	0	1,628	65.00
66.00	06600	PHYSICAL THERAPY	2,648	0	8,422	0	51	66.00
67.00	06700	OCCUPATIONAL THERAPY	793	0	2,831	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	34	0	260	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,199	0	5,090	3,161	289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	57,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	725	0	2,649	3,228	135	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	786	0	1,056	2,699	37	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,122	390	13,201	20,543	2,263	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)	41,095	83,026	113,577	113,017	98,656	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,274	0	1,394	16	15	192.00
192.01	19201	OCCUPATIONAL MEDICINE	740	0	1,212	1,103	150	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	48,109	83,026	116,183	114,136	98,821	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			15.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
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	70,185					15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	368	722,549	0	722,549		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219	626,334	0	626,334		50.00
53.00	05300	ANESTHESIOLOGY	0	11,370	0	11,370		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63	312,258	0	312,258		54.00
60.00	06000	LABORATORY	0	136,499	0	136,499		60.00
65.00	06500	RESPIRATORY THERAPY	0	20,908	0	20,908		65.00
66.00	06600	PHYSICAL THERAPY	0	145,160	0	145,160		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	43,830	0	43,830		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,172	0	2,172		68.00
69.00	06900	ELECTROCARDIOLOGY	11	88,854	0	88,854		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,594	0	16,594		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	65,166	0	65,166		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,431	86,963	0	86,963		73.00
73.01	03480	ONCOLOGY	112	54,226	0	54,226		73.01
73.02	07301	BLOOD DISORDER DRUGS	10,538	15,684	0	15,684		73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	54,305	0	54,305		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	443	374,851	0	374,851		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)	70,185	2,777,723	0	2,777,723		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	339,842	0	339,842		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	50,065	0	50,065		192.01
192.02	19202	VACANT SPACE	0	0	0	0		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	70,185	3,167,630	0	3,167,630		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	193,044					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	168,990				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			193,044			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	842	842	842	12,422,158		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,065	12,065	12,065	682,402	-7,910,059	5.00
7.00	00700	OPERATION OF PLANT	47,699	41,898	47,699	640,617	0	7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,123	3,123	3,123	19,670	0	8.00
9.00	00900	HOUSEKEEPING	1,865	1,865	1,865	389,243	0	9.00
10.00	01000	DIETARY	3,380	3,380	3,380	166,736	0	10.00
11.00	01100	CAFETERIA	4,741	4,741	4,741	233,884	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,334	4,334	4,334	563,867	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,008	4,008	4,008	0	0	14.00
15.00	01500	PHARMACY	2,219	2,219	2,219	752,067	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,118	19,118	19,118	2,440,569	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,333	23,333	23,333	1,271,783	0	50.00
53.00	05300	ANESTHESIOLOGY	440	440	440	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,092	12,092	12,092	1,137,374	0	54.00
60.00	06000	LABORATORY	4,956	4,956	4,956	8,657	0	60.00
65.00	06500	RESPIRATORY THERAPY	290	290	290	690,653	0	65.00
66.00	06600	PHYSICAL THERAPY	7,016	2,479	7,016	727,037	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,100	742	2,100	233,188	0	67.00
68.00	06800	SPEECH PATHOLOGY	90	32	90	26,398	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,177	3,177	3,177	520,538	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
73.01	03480	ONCOLOGY	1,921	1,921	1,921	254,483	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,083	2,083	2,083	100,397	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	13,570	13,570	13,570	1,376,504	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)	174,462	162,708	174,462	12,236,067	-7,910,059	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,621	4,321	16,621	106,912	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,961	1,961	1,961	79,179	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,662,728	238,108	1,266,794	2,335,072		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.613207	1.409006	6.562203	0.187976		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				13,963		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001124		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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,174,058					5.00
7.00	00700	OPERATION OF PLANT	4,553,213	120,424				7.00
7.01	00701	OPERATION OF PLANT - OFFSITE	0	0	12,014			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	171,796	3,123	0	2,592		8.00
9.00	00900	HOUSEKEEPING	667,061	1,865	0	0	127,450	9.00
10.00	01000	DIETARY	435,102	3,380	0	0	3,380	10.00
11.00	01100	CAFETERIA	566,187	4,741	0	0	4,741	11.00
13.00	01300	NURSING ADMINISTRATION	911,442	4,334	0	0	4,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	610,485	4,008	0	0	4,008	14.00
15.00	01500	PHARMACY	1,325,355	2,219	0	0	2,219	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,530,598	19,118	0	2,592	19,118	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,599,615	23,333	0	0	23,333	50.00
53.00	05300	ANESTHESIOLOGY	57,649	440	0	0	440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,702,372	12,092	0	0	12,092	54.00
60.00	06000	LABORATORY	1,571,281	4,956	0	0	4,956	60.00
65.00	06500	RESPIRATORY THERAPY	900,473	290	0	0	290	65.00
66.00	06600	PHYSICAL THERAPY	1,048,065	2,479	4,537	0	7,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,737	742	1,358	0	2,100	67.00
68.00	06800	SPEECH PATHOLOGY	35,467	32	58	0	90	68.00
69.00	06900	ELECTROCARDIOLOGY	706,030	3,177	0	0	3,177	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,735	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,275,247	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,570,759	0	0	0	0	73.00
73.01	03480	ONCOLOGY	364,965	1,921	0	0	1,921	73.01
73.02	07301	BLOOD DISORDER DRUGS	824,302	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	163,892	2,083	0	0	2,083	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,368,778	13,570	0	0	13,570	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)	31,609,606	107,903	5,953	2,592	108,868	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	399,986	10,560	6,061	0	16,621	192.00
192.01	19201	OCCUPATIONAL MEDICINE	164,466	1,961	0	0	1,961	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	7,910,059	5,672,630	0	361,142	918,911	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.245852	47.105477	0.000000	139.329475	7.209973	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	200,858	812,036	0	73,947	48,109	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006243	6.743141	0.000000	28.528935	0.377474	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 2:03 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
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
7.01	00701	OPERATION OF PLANT - OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	9,802					10.00
11.00	01100	CAFETERIA	0	13,422				11.00
13.00	01300	NURSING ADMINISTRATION	0	586	107,134			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,202,983		14.00
15.00	01500	PHARMACY	0	838	0	26,952	5,490,153	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,756	2,958	56,130	49,437	28,766	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,683	22,108	384,032	17,125	50.00
53.00	05300	ANESTHESIOLOGY	0	67	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,466	33	20,572	4,946	54.00
60.00	06000	LABORATORY	0	958	0	20,160	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	694	0	36,289	0	65.00
66.00	06600	PHYSICAL THERAPY	0	973	0	1,143	33	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	30	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	588	2,967	6,432	851	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	324,735	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,275,247	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,570,759	73.00
73.01	03480	ONCOLOGY	0	306	3,030	3,020	8,746	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	824,302	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	122	2,533	824	7	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	46	1,525	19,283	50,453	34,618	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)	9,802	13,121	106,084	2,199,296	5,490,153	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	161	15	340	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	140	1,035	3,347	0	192.01
192.02	19202	VACANT SPACE	0	0	0	0	0	192.02
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)	725,660	962,894	1,412,965	978,271	1,843,808	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	74.031830	71.739979	13.188764	0.444067	0.335839	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83,026	116,183	114,136	98,821	70,185	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.470312	8.656162	1.065357	0.044858	0.012784	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 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	7,504,510		7,504,510	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,094,681		5,094,681	0	0	50.00
53.00	05300	ANESTHESIOLOGY	100,527		100,527	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,894,088		2,894,088	0	0	54.00
60.00	06000	LABORATORY	2,304,451		2,304,451	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,203,511	0	1,203,511	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,543,415	0	1,543,415	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,126	0	478,126	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,495	0	48,495	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,136,625		1,136,625	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	548,776		548,776	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,155,064		2,155,064	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,229,531		7,229,531	0	0	73.00
73.01	03480	ONCOLOGY	625,224		625,224	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,303,791		1,303,791	0	0	73.02
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	359,851		359,851	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,089,365		4,089,365	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	783,928		783,928		0	92.00
200.00		Subtotal (see instructions)	39,403,959	0	39,403,959	0	0	200.00
201.00		Less Observation Beds	783,928		783,928		0	201.00
202.00		Total (see instructions)	38,620,031	0	38,620,031	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,843,038		6,843,038			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,497,450	28,461,725	30,959,175	0.164561	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	128,703	2,008,475	2,137,178	0.047037	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,563	10,641,964	11,333,527	0.255356	0.000000	54.00
60.00	06000	LABORATORY	1,133,242	5,096,284	6,229,526	0.369924	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	843,548	989,658	1,833,206	0.656506	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	558,909	1,995,165	2,554,074	0.604295	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,741	580,786	828,527	0.577080	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,525	65,031	103,556	0.468297	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	494,091	4,582,245	5,076,336	0.223907	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	553,024	4,356,373	4,909,397	0.111781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,016,850	12,375,865	15,392,715	0.140005	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,733,515	18,813,004	22,546,519	0.320650	0.000000	73.00
73.01	03480	ONCOLOGY	0	2,712,224	2,712,224	0.230521	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	10,621,709	10,621,709	0.122748	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	806,898	806,898	0.445968	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	643,637	15,231,637	15,875,274	0.257593	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,964,330	1,964,330	0.399082	0.000000	92.00
200.00		Subtotal (see instructions)	21,423,836	121,303,373	142,727,209			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,423,836	121,303,373	142,727,209			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
73.01	03480	ONCOLOGY	0.000000		73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000		73.02
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 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	7,504,510		7,504,510	0	7,504,510	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,094,681		5,094,681	0	5,094,681	50.00
53.00	05300	ANESTHESIOLOGY	100,527		100,527	0	100,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,894,088		2,894,088	0	2,894,088	54.00
60.00	06000	LABORATORY	2,304,451		2,304,451	0	2,304,451	60.00
65.00	06500	RESPIRATORY THERAPY	1,203,511	0	1,203,511	0	1,203,511	65.00
66.00	06600	PHYSICAL THERAPY	1,543,415	0	1,543,415	0	1,543,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,126	0	478,126	0	478,126	67.00
68.00	06800	SPEECH PATHOLOGY	48,495	0	48,495	0	48,495	68.00
69.00	06900	ELECTROCARDIOLOGY	1,136,625		1,136,625	0	1,136,625	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	548,776		548,776	0	548,776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,155,064		2,155,064	0	2,155,064	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,229,531		7,229,531	0	7,229,531	73.00
73.01	03480	ONCOLOGY	625,224		625,224	0	625,224	73.01
73.02	07301	BLOOD DISORDER DRUGS	1,303,791		1,303,791	0	1,303,791	73.02
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	359,851		359,851	0	359,851	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,089,365		4,089,365	0	4,089,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	783,928		783,928		783,928	92.00
200.00		Subtotal (see instructions)	39,403,959	0	39,403,959	0	39,403,959	200.00
201.00		Less Observation Beds	783,928		783,928		783,928	201.00
202.00		Total (see instructions)	38,620,031	0	38,620,031	0	38,620,031	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 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	6,843,038		6,843,038			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,497,450	28,461,725	30,959,175	0.164561	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	128,703	2,008,475	2,137,178	0.047037	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,563	10,641,964	11,333,527	0.255356	0.000000	54.00
60.00	06000	LABORATORY	1,133,242	5,096,284	6,229,526	0.369924	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	843,548	989,658	1,833,206	0.656506	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	558,909	1,995,165	2,554,074	0.604295	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	247,741	580,786	828,527	0.577080	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	38,525	65,031	103,556	0.468297	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	494,091	4,582,245	5,076,336	0.223907	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	553,024	4,356,373	4,909,397	0.111781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,016,850	12,375,865	15,392,715	0.140005	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,733,515	18,813,004	22,546,519	0.320650	0.000000	73.00
73.01	03480	ONCOLOGY	0	2,712,224	2,712,224	0.230521	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	10,621,709	10,621,709	0.122748	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	806,898	806,898	0.445968	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	643,637	15,231,637	15,875,274	0.257593	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,964,330	1,964,330	0.399082	0.000000	92.00
200.00		Subtotal (see instructions)	21,423,836	121,303,373	142,727,209			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,423,836	121,303,373	142,727,209			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
73.01	03480	ONCOLOGY	0.000000		73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000		73.02
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 2:03 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	626,334	30,959,175	0.020231	1,355,469	27,422	50.00
53.00	05300	ANESTHESIOLOGY	11,370	2,137,178	0.005320	70,569	375	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,258	11,333,527	0.027552	258,466	7,121	54.00
60.00	06000	LABORATORY	136,499	6,229,526	0.021912	461,220	10,106	60.00
65.00	06500	RESPIRATORY THERAPY	20,908	1,833,206	0.011405	378,290	4,314	65.00
66.00	06600	PHYSICAL THERAPY	145,160	2,554,074	0.056835	266,899	15,169	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,830	828,527	0.052901	127,488	6,744	67.00
68.00	06800	SPEECH PATHOLOGY	2,172	103,556	0.020974	18,884	396	68.00
69.00	06900	ELECTROCARDIOLOGY	88,854	5,076,336	0.017504	215,604	3,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,594	4,909,397	0.003380	331,889	1,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,166	15,392,715	0.004234	2,167,851	9,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,963	22,546,519	0.003857	1,319,349	5,089	73.00
73.01	03480	ONCOLOGY	54,226	2,712,224	0.019993	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	15,684	10,621,709	0.001477	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	54,305	806,898	0.067301	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	374,851	15,875,274	0.023612	15,788	373	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	75,478	1,964,330	0.038424	0	0	92.00
200.00		Total (lines 50 through 199)	2,130,652	135,884,171		6,987,766	91,184	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 2:03 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 2:03 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	30,959,175	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,137,178	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,333,527	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,229,526	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,833,206	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,554,074	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	828,527	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	103,556	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,076,336	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,909,397	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,392,715	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,546,519	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	2,712,224	0.000000	73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0	0	10,621,709	0.000000	73.02
76.00	03160	CARDIOPULMONARY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	806,898	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	15,875,274	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,964,330	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	135,884,171		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 2:03 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	1,355,469	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	70,569	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	258,466	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	461,220	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	378,290	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	266,899	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	127,488	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,884	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	215,604	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	331,889	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,167,851	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,319,349	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.000000	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	15,788	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,987,766	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 2:03 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	0.164561	0	4,858,495	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047037	0	191,944	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.255356	0	2,859,124	0	0	54.00
60.00	06000	LABORATORY	0.369924	0	1,274,648	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.656506	0	351,616	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.604295	0	707,487	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577080	0	158,308	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.468297	0	11,331	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223907	0	1,498,921	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111781	0	1,031,014	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140005	0	3,311,776	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320650	0	9,505,328	5,523	0	73.00
73.01	03480	ONCOLOGY	0.230521	0	1,303,804	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.122748	0	3,599,167	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.445968	0	383,409	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.257593	0	3,580,570	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.399082	0	312,684	3,601	0	92.00
200.00		Subtotal (see instructions)		0	34,939,626	9,124	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	34,939,626	9,124	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 2:03 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	799,519	0		50.00
53.00	05300	ANESTHESIOLOGY	9,028	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,094	0		54.00
60.00	06000	LABORATORY	471,523	0		60.00
65.00	06500	RESPIRATORY THERAPY	230,838	0		65.00
66.00	06600	PHYSICAL THERAPY	427,531	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	91,356	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,306	0		68.00
69.00	06900	ELECTROCARDIOLOGY	335,619	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	115,248	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	463,665	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,047,883	1,771		73.00
73.01	03480	ONCOLOGY	300,554	0		73.01
73.02	07301	BLOOD DISORDER DRUGS	441,791	0		73.02
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	170,988	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	922,330	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,787	1,437		92.00
200.00		Subtotal (see instructions)	8,688,060	3,208		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,688,060	3,208		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 2:03 pm

Title XIX | 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	0.164561	0	784,891	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047037	0	101,434	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.255356	0	52,687	0	0	54.00
60.00	06000	LABORATORY	0.369924	0	36,496	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.656506	0	602	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.604295	0	2,978	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577080	0	4,376	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.468297	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223907	0	18,337	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111781	0	30,012	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140005	0	68,563	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320650	0	361,001	0	0	73.00
73.01	03480	ONCOLOGY	0.230521	0	44,136	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.122748	0	0	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.445968	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.257593	0	103,779	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.399082	0	9,889	0	0	92.00
200.00		Subtotal (see instructions)		0	1,619,181	0	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	1,619,181	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 2:03 pm

Title XIX | 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	129,162	0		50.00
53.00	05300	ANESTHESIOLOGY	4,771	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,454	0		54.00
60.00	06000	LABORATORY	13,501	0		60.00
65.00	06500	RESPIRATORY THERAPY	395	0		65.00
66.00	06600	PHYSICAL THERAPY	1,800	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,525	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,106	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,355	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,599	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,755	0		73.00
73.01	03480	ONCOLOGY	10,174	0		73.01
73.02	07301	BLOOD DISORDER DRUGS	0	0		73.02
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	26,733	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,947	0		92.00
200.00		Subtotal (see instructions)	339,277	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	339,277	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 2:03 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)	2,979	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,903	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)	2,592	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	74	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	2	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,172	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)	74	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)	7,504,510	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)	462	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)	186,992	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,317,518	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,317,518	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)	2,520.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,954,225	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,954,225	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 2:03 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						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)	1,771,043	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,725,268	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)	186,530	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)	186,530	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)	311	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,520.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	783,928	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 2:03 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	722,549	7,504,510	0.096282	783,928	75,478	90.00
91.00	Nursing Program cost	0	7,504,510	0.000000	783,928	0	91.00
92.00	Allied health cost	0	7,504,510	0.000000	783,928	0	92.00
93.00	All other Medical Education	0	7,504,510	0.000000	783,928	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 2:03 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)	2,979	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,903	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.	3	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,589	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	74	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	2	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)	3	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,504,510	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	186,541	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,317,969	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,317,969	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)	2,520.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,562	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)	7,562	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 2:03 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						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)	5,304	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,866	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)	311	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,520.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	783,978	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 2:03 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	722,549	7,504,510	0.096282	783,978	75,483	90.00
91.00	Nursing Program cost	0	7,504,510	0.000000	783,978	0	91.00
92.00	Allied health cost	0	7,504,510	0.000000	783,978	0	92.00
93.00	All other Medical Education	0	7,504,510	0.000000	783,978	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 2:03 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		2,986,184		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164561	1,355,469	223,057	50.00
53.00	05300	ANESTHESIOLOGY	0.047037	70,569	3,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.255356	258,466	66,001	54.00
60.00	06000	LABORATORY	0.369924	461,220	170,616	60.00
65.00	06500	RESPIRATORY THERAPY	0.656506	378,290	248,350	65.00
66.00	06600	PHYSICAL THERAPY	0.604295	266,899	161,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577080	127,488	73,571	67.00
68.00	06800	SPEECH PATHOLOGY	0.468297	18,884	8,843	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223907	215,604	48,275	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111781	331,889	37,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140005	2,167,851	303,510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320650	1,319,349	423,049	73.00
73.01	03480	ONCOLOGY	0.230521	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.122748	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.445968	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.257593	15,788	4,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.399082	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,987,766	1,771,043	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)		6,987,766		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3

Component CCN: 15-Z311 | Date/Time Prepared: 5/26/2022 2:03 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164561	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047037	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.255356	524	134	54.00
60.00	06000	LABORATORY	0.369924	4,765	1,763	60.00
65.00	06500	RESPIRATORY THERAPY	0.656506	5,404	3,548	65.00
66.00	06600	PHYSICAL THERAPY	0.604295	31,383	18,965	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577080	15,426	8,902	67.00
68.00	06800	SPEECH PATHOLOGY	0.468297	2,572	1,204	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223907	3,336	747	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111781	608	68	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140005	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320650	9,421	3,021	73.00
73.01	03480	ONCOLOGY	0.230521	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.122748	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.445968	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.257593	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.399082	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		73,439	38,352	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)		73,439		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 2:03 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		15,144		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164561	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047037	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.255356	524	134	54.00
60.00	06000	LABORATORY	0.369924	1,457	539	60.00
65.00	06500	RESPIRATORY THERAPY	0.656506	4,141	2,719	65.00
66.00	06600	PHYSICAL THERAPY	0.604295	785	474	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.577080	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.468297	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.223907	236	53	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140005	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320650	2,162	693	73.00
73.01	03480	ONCOLOGY	0.230521	0	0	73.01
73.02	07301	BLOOD DISORDER DRUGS	0.122748	0	0	73.02
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.445968	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.257593	2,688	692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.399082	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,993	5,304	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)		11,993		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part B Date/Time Prepared: 5/26/2022 2:03 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,691,268	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)	8,691,268	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)	8,778,181	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)	28,592	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,609,929	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)	2,139,660	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)	2,139,660	30.00
31.00	Primary payer payments	1,487	31.00
32.00	Subtotal (line 30 minus line 31)	2,138,173	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)	1,503,301	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	977,146	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,246,814	36.00
37.00	Subtotal (see instructions)	3,115,319	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)	3,115,319	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	4,993,930	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)	-1,878,611	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	282,737	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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2022 2:03 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		4,771,960		4,993,930	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	11/14/2021	771,700		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)		771,700		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)		5,543,660		4,993,930	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		1,120,263		1,878,611	6.02
7.00	Total Medicare program liability (see instructions)		4,423,397		3,115,319	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 2:03 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		219,566		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)		219,566		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		5,339		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		224,905		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: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 2:03 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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 2:03 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)	188,395	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)	38,736	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	74	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)	227,131	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	227,131	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)	227,131	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,226	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	224,905	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)	224,905	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	219,566	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)	5,339	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	7,176	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: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 2:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,725,268	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)	4,725,268	4.00
5.00	Primary payer payments	385	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,772,136	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)	4,772,136	19.00
20.00	Deductibles (exclude professional component)	373,816	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,398,320	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,398,320	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	38,580	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	25,077	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,688	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,423,397	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)	4,423,397	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	5,543,660	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)	-1,120,263	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	154,099	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 2:03 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	46,139,504	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	6,729,642	0	0	0	4.00
5.00	Other receivable	344,548	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,059,929	0	0	0	7.00
8.00	Prepaid expenses	116,527	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)	54,390,150	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,139,179	0	0	0	17.00
18.00	Accumulated depreciation	-1,611,187	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	5,837	0	0	0	21.00
22.00	Accumulated depreciation	-5,837	0	0	0	22.00
23.00	Major movable equipment	14,232,529	0	0	0	23.00
24.00	Accumulated depreciation	-10,006,678	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,753,843	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	27,239,520	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,239,520	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,383,513	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,819,052	0	0	0	37.00
38.00	Salaries, wages, and fees payable	920,846	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,633,466	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,373,364	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	11,965,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	329,542	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,294,542	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,667,906	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	60,715,607				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)	60,715,607	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,383,513	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 2:03 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		47,765,630		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,871,990				2.00
3.00	Total (sum of line 1 and line 2)		58,637,620		0		3.00
4.00	DONATED PROP., PLANT, EQUIP.	14,205		0		0	4.00
5.00	TEMP RESTRICTED	1,106,721		0		0	5.00
6.00	PERM RESTRICTED	957,039		0		0	6.00
7.00	ROUNDING	22		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)		2,077,987		0		10.00
11.00	Subtotal (line 3 plus line 10)		60,715,607		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)		60,715,607		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 PROP., PLANT, EQUIP.		0		4.00
5.00	TEMP RESTRICTED		0		5.00
6.00	PERM RESTRICTED		0		6.00
7.00	ROUNDING		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: 15-1311 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2022 2:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,774,258		6,774,258	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	68,780		68,780	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)	6,843,038		6,843,038	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,843,038		6,843,038	17.00
18.00	Ancillary services	13,937,161	104,107,406	118,044,567	18.00
19.00	Outpatient services	643,637	17,195,967	17,839,604	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	NONALLOWABLE/PHYSICIAN REVENUE	0	1,730,254	1,730,254	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,423,836	123,033,627	144,457,463	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,657,007		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)		42,657,007		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/26/2022 2:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,457,463	1.00
2.00	Less contractual allowances and discounts on patients' accounts	96,343,294	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,114,169	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,657,007	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,457,162	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	1,216,334	24.00
24.50	COVID-19 PHE Funding	4,198,494	24.50
25.00	Total other income (sum of lines 6-24)	5,414,828	25.00
26.00	Total (line 5 plus line 25)	10,871,990	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)	10,871,990	29.00