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: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 3:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2022 Time: 3:45 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 WHITE HOSPITAL (15-1312) 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	Todd Williams		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	Todd Williams			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-142,769	-1,445,542	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	-63,032	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-205,801	-1,445,542	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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:45 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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 WHITE HOSPITAL	151312	99915	1	07/01/1966	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 WHITE HOSPITAL	15Z312	99915		02/16/1990	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:45 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: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:45 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:45 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 3:45 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:45 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	34,577	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2022 3:45 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	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)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	162	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2022 3:45 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	04/01/2022	Y	04/01/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 3:45 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.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 3:45 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.	GOVERNMENT PROGRAMS DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:45 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	61,440.00	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	61,440.00	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	61,440.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:45 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)	1,160	37	2,560			1.00
2.00	HMO and other (see instructions)	691	170				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	380	0	380			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	388			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,540	37	3,328			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)	1,540	37	3,328	0.00	141.75	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			36			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	141.75	27.00
28.00	Observation Bed Days		3	561			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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2022 3:45 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	290	10	677	1.00
2.00	HMO and other (see instructions)			163	54		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	290	10	677	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/26/2022 3:45 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)	0.283993	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,460,874	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	22,134,053	6.00
7.00	Medicaid cost (line 1 times line 6)	6,285,916	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,825,042	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)	18,696	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	190,614	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	54,133	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)	35,437	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,860,479	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,590,987	364,100	2,955,087	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	735,822	364,100	1,099,922	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)	735,822	364,100	1,099,922	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)	3,079,043	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	436,572	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	671,649	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,407,394	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	918,760	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,018,682	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,879,161	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:45 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	0	0	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,553,994	2,553,994	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	233,328	233,328	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-966	39,894	38,928	1,795,251	1,834,179	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	478,642	8,839,169	9,317,811	-1,809,701	7,508,110	5.00
7.00	00700	OPERATION OF PLANT	458,047	1,903,913	2,361,960	-1,844,131	517,829	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	1,656,991	1,656,991	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	345,403	345,403	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	61,977	61,977	8.00
9.00	00900	HOUSEKEEPING	348,394	408,996	757,390	-159,571	597,819	9.00
10.00	01000	DIETARY	433,807	585,286	1,019,093	-269,483	749,610	10.00
11.00	01100	CAFETERIA	0	0	0	149,440	149,440	11.00
13.00	01300	NURSING ADMINISTRATION	1,165,425	363,242	1,528,667	-337,676	1,190,991	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-83	-25,256	-25,339	232,168	206,829	14.00
15.00	01500	PHARMACY	438,512	4,795,038	5,233,550	-4,351,945	881,605	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,880,659	1,282,563	3,163,222	-376,094	2,787,128	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	401,041	794,795	1,195,836	-355,543	840,293	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281,166	292,994	574,160	-247,901	326,259	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55,136	114,080	169,216	-52,669	116,547	55.00
56.00	05600	RADIOISOTOPE	139,811	74,807	214,618	-59,591	155,027	56.00
57.00	05700	CT SCAN	426,358	225,653	652,011	-189,234	462,777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	183,094	321,563	504,657	-111,682	392,975	58.00
60.00	06000	LABORATORY	0	1,654,138	1,654,138	-727	1,653,411	60.00
66.00	06600	PHYSICAL THERAPY	453,308	128,692	582,000	-101,186	480,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,052	32,107	195,159	-17,126	178,033	67.00
68.00	06800	SPEECH PATHOLOGY	94,704	25,277	119,981	-18,695	101,286	68.00
69.00	06900	ELECTROCARDIOLOGY	136,015	69,617	205,632	-56,094	149,538	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	77,206	77,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,626	11,626	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,077,598	1,077,598	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	3,409,704	3,409,704	73.01
76.00	03160	CARDIOPULMONARY	531,764	294,884	826,648	-82,915	743,733	76.00
76.97	07697	CARDIAC REHABILITATION	103,076	59,646	162,722	-43,868	118,854	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	211,304	122,764	334,068	-89,680	244,388	90.00
91.00	09100	EMERGENCY	1,255,494	2,002,290	3,257,784	-429,464	2,828,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,637,760	24,406,152	34,043,912	599,710	34,643,622	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67,635	42,133	109,768	-22,920	86,848	192.00
192.02	19202	MOB	0	576,790	576,790	-576,790	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	9,705,395	25,025,075	34,730,470	0	34,730,470	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/26/2022 3:45 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	58,198	58,198		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	217,466	2,771,460		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	291,695	525,023		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-69,231	1,764,948		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	743,365	8,251,475		5.00
7.00	00700	OPERATION OF PLANT	-19,833	497,996		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	99,499	1,756,490		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	345,403		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,977		8.00
9.00	00900	HOUSEKEEPING	0	597,819		9.00
10.00	01000	DIETARY	-315,504	434,106		10.00
11.00	01100	CAFETERIA	-11,455	137,985		11.00
13.00	01300	NURSING ADMINISTRATION	104,230	1,295,221		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-4,835	201,994		14.00
15.00	01500	PHARMACY	337,773	1,219,378		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-219,296	2,567,832		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-129,114	711,179		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-707	325,552		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	116,547		55.00
56.00	05600	RADIOISOTOPE	0	155,027		56.00
57.00	05700	CT SCAN	0	462,777		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	392,975		58.00
60.00	06000	LABORATORY	0	1,653,411		60.00
66.00	06600	PHYSICAL THERAPY	0	480,814		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,033		67.00
68.00	06800	SPEECH PATHOLOGY	0	101,286		68.00
69.00	06900	ELECTROCARDIOLOGY	0	149,538		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,206		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,626		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,077,598		73.00
73.01	07301	ONCOLOGY DRUGS	0	3,409,704		73.01
76.00	03160	CARDIOPULMONARY	77,459	821,192		76.00
76.97	07697	CARDIAC REHABILITATION	0	118,854		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	244,388		90.00
91.00	09100	EMERGENCY	43,490	2,871,810		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,203,200	35,846,822		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	86,848		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,203,200	35,933,670		200.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:45 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	60,681	88,759	1.00
	0		60,681	88,759	
	B - DRUGS EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,077,598	1.00
2.00	ONCOLOGY DRUGS	73.01	0	3,409,704	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
	0		0	4,487,302	
	C - MEDICAL SUPPLIES AND REBATES				
1.00	CENTRAL SERVICES & SUPPLY	14.00		244,263	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		77,206	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		11,626	3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		3	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00		1,317	5.00
6.00	DIETARY	10.00		144	6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00		950	7.00
8.00	CT SCAN	57.00		1,921	8.00
9.00	OCCUPATIONAL THERAPY	67.00		16	9.00
10.00	CARDIAC REHABILITATION	76.97		15	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
	0		0	337,461	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	61,977	1.00
	0		0	61,977	
	E - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01		1,565,017	1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02		217,226	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
	0		0	1,782,243	
	F - OTHER CAPITAL EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	963,513	1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	25,464	2.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:45 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
3.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	16,102		3.00
	0		0	1,005,079		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	1,656,991		1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	345,403		2.00
	0		0	2,002,394		
	H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,777,983		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	1,777,983		
	I - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	11,014		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
	0		0	11,014		
	K - CNO					
1.00	NURSING ADMINISTRATION	13.00	130,438	0		1.00
	0		130,438	0		
	L - ACCRUED PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,679	0		1.00
2.00	HOUSEKEEPING	9.00	335	0		2.00
3.00	DIETARY	10.00	12,371	0		3.00
4.00	PHARMACY	15.00	12,465	0		4.00
5.00	OPERATING ROOM	50.00	5,867	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	10,478	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	2,221	0		7.00
8.00	EMERGENCY	91.00	9,285	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	324	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
	0		72,025	0		

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:45 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	N - INVENTORY MANAGEMENT				
1.00	CENTRAL SERVICES & SUPPLY	14.00	83	0	1.00
	TOTALS		83	0	
	O - EMERGENCY PREPAREDNESS				
1.00	ADULTS & PEDIATRICS	30.00	180,170	15,149	1.00
2.00	CARDIOPULMONARY	76.00	75,957	6,387	2.00
3.00	EMERGENCY	91.00	2,292	193	3.00
	TOTALS		258,419	21,729	
500.00	Grand Total: Increases		521,646	11,575,941	500.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:45 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	60,681	88,759	0		1.00
	0		60,681	88,759			
	B - DRUGS EXPENSE						
1.00	PHARMACY	15.00		4,264,405	0		1.00
2.00	NURSING ADMINISTRATION	13.00		148	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		10,285	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		20,346	0		4.00
5.00	OPERATING ROOM	50.00		9,688	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00		4,195	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00		7,333	0		7.00
8.00	RADIOISOTOPE	56.00		10,426	0		8.00
9.00	CT SCAN	57.00		70,568	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		13,177	0		10.00
11.00	ELECTROCARDIOLOGY	69.00		2,567	0		11.00
12.00	CARDIOPULMONARY	76.00		4,924	0		12.00
13.00	CARDIAC REHABILITATION	76.97		33	0		13.00
14.00	CLINIC	90.00		10,450	0		14.00
15.00	EMERGENCY	91.00		58,757	0		15.00
	0		0	4,487,302			
	C - MEDICAL SUPPLIES AND REBATES						
1.00	CENTRAL SERVICES & SUPPLY	14.00		1,809	0		1.00
2.00	OPERATION OF PLANT	7.00		21,939	0		2.00
3.00	HOUSEKEEPING	9.00		777	0		3.00
4.00	NURSING ADMINISTRATION	13.00		31	0		4.00
5.00	PHARMACY	15.00		7,434	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		46,952	0		6.00
7.00	OPERATING ROOM	50.00		119,691	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		977	0		8.00
9.00	RADIOISOTOPE	56.00		5,726	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		523	0		10.00
11.00	LABORATORY	60.00		727	0		11.00
12.00	PHYSICAL THERAPY	66.00		1,899	0		12.00
13.00	SPEECH PATHOLOGY	68.00		2	0		13.00
14.00	ELECTROCARDIOLOGY	69.00		7,863	0		14.00
15.00	CARDIOPULMONARY	76.00		28,999	0		15.00
16.00	CLINIC	90.00		17,620	0		16.00
17.00	EMERGENCY	91.00		74,425	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00		67	0		18.00
	0		0	337,461			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	61,977	0		1.00
	0		0	61,977			
	E - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1,414	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		649,417	9		2.00
3.00	OPERATION OF PLANT	7.00		60,780	0		3.00
4.00	DIETARY	10.00		26,238	0		4.00
5.00	NURSING ADMINISTRATION	13.00		6,840	0		5.00
6.00	PHARMACY	15.00		27,616	0		6.00
7.00	ADULTS & PEDIATRICS	30.00		125,750	0		7.00
8.00	OPERATING ROOM	50.00		161,693	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		182,260	0		9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00		29,334	0		10.00
11.00	RADIOISOTOPE	56.00		6,999	0		11.00
12.00	CT SCAN	57.00		79,336	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		77,133	0		13.00
14.00	PHYSICAL THERAPY	66.00		527	0		14.00
15.00	ELECTROCARDIOLOGY	69.00		3,890	0		15.00
16.00	CARDIOPULMONARY	76.00		7,635	0		16.00
17.00	CARDIAC REHABILITATION	76.97		9,795	0		17.00
18.00	EMERGENCY	91.00		108,360	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00		1,941	0		19.00
20.00	MOB	192.02		215,285	0		20.00
	0		0	1,782,243			
	F - OTHER CAPITAL EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	963,513	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	25,464	12		2.00
3.00	MOB	192.02	0	16,102	13		3.00
	0		0	1,005,079			

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:45 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT	7.00	0	1,656,991	0	1.00
2.00	MOB	192.02	0	345,403	0	2.00
	0		0	2,002,394		
	H - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00		40,320	0	1.00
2.00	OPERATION OF PLANT	7.00		102,013	0	2.00
3.00	HOUSEKEEPING	9.00		108,166	0	3.00
4.00	DIETARY	10.00		99,951	0	4.00
5.00	NURSING ADMINISTRATION	13.00		172,992	0	5.00
6.00	PHARMACY	15.00		62,673	0	6.00
7.00	ADULTS & PEDIATRICS	30.00		344,857	0	7.00
8.00	OPERATING ROOM	50.00		70,329	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		56,553	0	9.00
10.00	RADIOLOGY-THERAPEUTIC	55.00		27,430	0	10.00
11.00	RADIOISOTOPE	56.00		34,750	0	11.00
12.00	CT SCAN	57.00		41,227	0	12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		18,887	0	13.00
14.00	PHYSICAL THERAPY	66.00		91,567	0	14.00
15.00	OCCUPATIONAL THERAPY	67.00		19,363	0	15.00
16.00	SPEECH PATHOLOGY	68.00		18,245	0	16.00
17.00	ELECTROCARDIOLOGY	69.00		38,312	0	17.00
18.00	CARDIOPULMONARY	76.00		117,365	0	18.00
19.00	CARDIAC REHABILITATION	76.97		32,649	0	19.00
20.00	CLINIC	90.00		59,868	0	20.00
21.00	EMERGENCY	91.00		199,240	0	21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00		21,226	0	22.00
	0		0	1,777,983		
	I - HOUSEKEEPING SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00		4	0	1.00
2.00	OPERATION OF PLANT	7.00		2	0	2.00
3.00	DIETARY	10.00		6,369	0	3.00
4.00	NURSING ADMINISTRATION	13.00		126	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00		1	0	5.00
6.00	PHARMACY	15.00		2,282	0	6.00
7.00	ADULTS & PEDIATRICS	30.00		1,324	0	7.00
8.00	OPERATING ROOM	50.00		9	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		55	0	9.00
10.00	RADIOISOTOPE	56.00		168	0	10.00
11.00	CT SCAN	57.00		16	0	11.00
12.00	PHYSICAL THERAPY	66.00		19	0	12.00
13.00	ELECTROCARDIOLOGY	69.00		27	0	13.00
14.00	CARDIOPULMONARY	76.00		128	0	14.00
15.00	CARDIAC REHABILITATION	76.97		4	0	15.00
16.00	CLINIC	90.00		18	0	16.00
17.00	EMERGENCY	91.00		452	0	17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00		10	0	18.00
	0		0	11,014		
	K - CNO					
1.00	ADMINISTRATIVE & GENERAL	5.00	130,438	0	0	1.00
	0		130,438	0		
	L - ACCRUED PTO					
1.00	ADMINISTRATIVE & GENERAL	5.00	1,862	0	0	1.00
2.00	OPERATION OF PLANT	7.00	2,406	0	0	2.00
3.00	NURSING ADMINISTRATION	13.00	7,829	0	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	32,184	0	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,861	0	0	5.00
6.00	RADIOISOTOPE	56.00	1,522	0	0	6.00
7.00	CT SCAN	57.00	8	0	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,962	0	0	8.00
9.00	PHYSICAL THERAPY	66.00	7,174	0	0	9.00
10.00	SPEECH PATHOLOGY	68.00	448	0	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	3,435	0	0	11.00
12.00	CARDIOPULMONARY	76.00	6,208	0	0	12.00
13.00	CARDIAC REHABILITATION	76.97	1,402	0	0	13.00
14.00	CLINIC	90.00	1,724	0	0	14.00
	0		72,025	0		
	N - INVENTORY MANAGEMENT					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	83	0	1.00
	TOTALS		0	83		

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/26/2022 3:45 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - EMERGENCY PREPAREDNESS						
1.00	NURSING ADMINISTRATION	13.00	258,419	21,729	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		258,419	21,729			
500.00	Grand Total: Decreases		521,563	11,576,024			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2022 3:45 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	954,570	0	0	0	0	1.00
2.00	Land Improvements	813,560	0	0	0	109,360	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	38,459,462	0	0	0	93,828	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,744,361	2,549,817	0	2,549,817	5,188	6.00
7.00	HIT designated Assets	15,000	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	48,986,953	2,549,817	0	2,549,817	208,376	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	48,986,953	2,549,817	0	2,549,817	208,376	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	704,200	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	38,365,634	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,288,990	3,238,793	6.00
7.00	HIT designated Assets	15,000	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	51,328,394	3,253,793	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	51,328,394	3,253,793	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2022 3:45 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 - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
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 - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2022 3:45 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,658,770	0	1,658,770	0.032317	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	34,739,609	0	34,739,609	0.676811	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	14,930,016	0	14,930,016	0.290872	0	1.02
3.00	Total (sum of lines 1-2)	51,328,395	0	51,328,395	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	30,355	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,844,297	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	508,921	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,383,573	0	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	27,843	0	0	0	58,198	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	901,699	25,464	0	0	2,771,460	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	16,102	0	525,023	1.02
3.00	Total (sum of lines 1-2)	929,542	25,464	16,102	0	3,354,681	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:45 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	27,843	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-476,165			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	4,856,254			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-11,455	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	30,355	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	181,752	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	291,695	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/26/2022 3:45 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	EMPLOYEE BENEFITS	A	-1,777,945	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.01
33.02	MEDICAID HAF FEES	A	-1,689,698	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-2,076	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,835	CENTRAL SERVICES & SUPPLY	14.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-3,712	PHARMACY	15.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-707	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	WIC PROGRAM COSTS	A	-268,074	DIETARY	10.00	0	33.07
33.08	WIC PROGRAM BENEFIT COSTS	A	-39,987	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	CONTRIBUTION EXPENSE	A	-7,000	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TELEPHONE EXPENSE	A	-523	ADULTS & PEDIATRICS	30.00	0	33.10
33.11	MARKETING	A	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,203,200				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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 3:45 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	1.01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	935,442	997,256	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,748,701	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5,776,561	4,559,968	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	POOLED CAPITAL - H.O.	289,747	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,715,484	779,635	4.00
4.01	7.00	OPERATION OF PLANT	RELATED PARTY	0	19,833	4.01
4.02	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	130,380	30,881	4.02
4.03	10.00	DIETARY	RELATED PARTY	21,636	69,066	4.03
4.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	140,849	36,619	4.04
4.05	15.00	PHARMACY	RELATED PARTY	608,938	267,453	4.05
4.06	30.00	ADULTS & PEDIATRICS	RELATED PARTY	191,868	115,388	4.06
4.07	50.00	OPERATING ROOM	RELATED PARTY	208,258	156,460	4.07
4.08	76.00	CARDIOPULMONARY	RELATED PARTY	161,393	83,934	4.08
4.09	91.00	EMERGENCY	RELATED PARTY	125,997	82,507	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	119	119	4.10
4.11	15.00	PHARMACY	SHARED EMPLOYEES	420	420	4.11
4.12	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	327,063	327,063	4.12
4.13	50.00	OPERATING ROOM	SHARED EMPLOYEES	178,545	178,545	4.13
4.14	60.00	LABORATORY	SHARED EMPLOYEES	1,554,672	1,554,672	4.14
4.15	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	96,605	96,605	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,212,678	9,356,424	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2022 3:45 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	-61,814	11		1.00
2.00	1,748,701	0		2.00
3.00	1,216,593	0		3.00
3.01	289,747	0		3.01
4.00	935,849	0		4.00
4.01	-19,833	0		4.01
4.02	99,499	0		4.02
4.03	-47,430	0		4.03
4.04	104,230	0		4.04
4.05	341,485	0		4.05
4.06	76,480	0		4.06
4.07	51,798	0		4.07
4.08	77,459	0		4.08
4.09	43,490	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
5.00	4,856,254			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2022 3:45 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	295,253	295,253	0	0	0	1.00
2.00	50.00	OPERATING ROOM	180,912	180,912	0	0	0	2.00
3.00	91.00	EMERGENCY	1,200,233	0	1,200,233	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,676,398	476,165	1,200,233		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	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	295,253		1.00
2.00	50.00	OPERATING ROOM	0	0	0	180,912		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	476,165		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	58,198	58,198				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,771,460	0	2,771,460			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	525,023	0	0	525,023		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,764,948	0	0	0	1,764,948	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,251,475	5,351	113,411	89,556	63,098	5.00
7.00	00700	OPERATION OF PLANT	497,996	0	0	0	83,010	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,756,490	8,044	631,640	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	345,403	4,376	0	100,321	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	61,977	259	20,340	0	0	8.00
9.00	00900	HOUSEKEEPING	597,819	864	62,321	1,604	63,532	9.00
10.00	01000	DIETARY	434,106	2,228	0	51,082	70,231	10.00
11.00	01100	CAFETERIA	137,985	692	0	15,859	11,055	11.00
13.00	01300	NURSING ADMINISTRATION	1,295,221	837	33,305	9,471	187,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	201,994	2,290	179,780	0	0	14.00
15.00	01500	PHARMACY	1,219,378	978	76,780	0	82,160	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,567,832	4,933	387,323	0	369,587	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	711,179	4,142	325,195	0	74,132	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,552	1,568	123,147	0	50,520	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	116,547	322	25,304	0	11,954	55.00
56.00	05600	RADIOISOTOPE	155,027	222	17,448	0	25,194	56.00
57.00	05700	CT SCAN	462,777	303	23,810	0	77,674	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	392,975	428	33,594	0	32,999	58.00
60.00	06000	LABORATORY	1,653,411	1,423	111,772	0	0	60.00
66.00	06600	PHYSICAL THERAPY	480,814	1,379	108,302	0	81,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,033	110	8,628	0	30,110	67.00
68.00	06800	SPEECH PATHOLOGY	101,286	52	4,049	0	17,172	68.00
69.00	06900	ELECTROCARDIOLOGY	149,538	328	25,738	0	24,154	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,206	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,626	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,598	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,409,704	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	821,192	648	50,898	0	109,585	76.00
76.97	07697	CARDIAC REHABILITATION	118,854	786	0	18,013	18,523	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	244,388	2,138	167,875	0	38,182	90.00
91.00	09100	EMERGENCY	2,871,810	3,067	240,800	0	230,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,846,822	47,768	2,771,460	285,906	1,752,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,848	1,830	0	41,964	12,381	192.00
192.02	19202	MOB	0	6,792	0	155,710	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,808	0	41,443	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,933,670	58,198	2,771,460	525,023	1,764,948	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,522,891	8,522,891				5.00
7.00	00700	OPERATION OF PLANT	581,006	180,653	761,659			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,396,174	745,047	115,941	3,257,162		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	450,100	139,950	63,070	0	653,120	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	82,576	25,676	3,733	32,693	0	8.00
9.00	00900	HOUSEKEEPING	726,140	225,780	12,448	100,172	3,126	9.00
10.00	01000	DIETARY	557,647	173,390	32,114	0	99,548	10.00
11.00	01100	CAFETERIA	165,591	51,488	9,970	0	30,906	11.00
13.00	01300	NURSING ADMINISTRATION	1,526,412	474,610	12,067	53,533	18,456	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	384,064	119,418	32,999	288,971	0	14.00
15.00	01500	PHARMACY	1,379,296	428,867	14,093	123,413	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,329,675	1,035,303	71,094	622,565	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,114,648	346,580	59,690	522,705	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	500,787	155,711	22,604	197,941	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	154,127	47,923	4,645	40,673	0	55.00
56.00	05600	RADIOISOTOPE	197,891	61,531	3,203	28,045	0	56.00
57.00	05700	CT SCAN	564,564	175,541	4,370	38,271	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	459,996	143,027	6,166	53,998	0	58.00
60.00	06000	LABORATORY	1,766,606	549,294	20,516	179,658	0	60.00
66.00	06600	PHYSICAL THERAPY	671,773	208,876	19,879	174,080	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,881	67,435	1,584	13,868	0	67.00
68.00	06800	SPEECH PATHOLOGY	122,559	38,108	743	6,508	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,758	62,111	4,724	41,370	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,206	24,006	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,626	3,615	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,598	335,060	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,409,704	1,060,188	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	982,323	305,436	9,342	81,811	0	76.00
76.97	07697	CARDIAC REHABILITATION	156,176	48,560	11,324	0	35,102	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	452,583	140,723	30,814	269,836	0	90.00
91.00	09100	EMERGENCY	3,346,516	1,040,539	44,199	387,051	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,584,894	8,414,446	611,332	3,257,162	187,138	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143,023	44,470	26,382	0	81,777	192.00
192.02	19202	MOB	162,502	50,527	97,891	0	303,443	192.02
192.03	19203	ARNETT SURGERY OFFICE	43,251	13,448	26,054	0	80,762	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,933,670	8,522,891	761,659	3,257,162	653,120	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	144,678					8.00
9.00	00900	HOUSEKEEPING	0	1,067,666				9.00
10.00	01000	DIETARY	0	31,982	894,681			10.00
11.00	01100	CAFETERIA	0	9,906	0	267,861		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,697	0	25,526	2,115,301	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,461	0	0	0	14.00
15.00	01500	PHARMACY	0	13,109	0	11,009	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	144,678	202,013	894,681	56,956	1,183,185	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	148,168	0	12,775	175,050	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,364	0	10,767	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,423	0	1,621	0	55.00
56.00	05600	RADIOISOTOPE	0	7,985	0	3,895	0	56.00
57.00	05700	CT SCAN	0	10,888	0	14,614	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,372	0	5,831	0	58.00
60.00	06000	LABORATORY	0	28,481	0	23,735	0	60.00
66.00	06600	PHYSICAL THERAPY	0	31,214	0	13,065	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,477	0	4,839	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,153	0	2,419	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,653	0	4,839	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	17,592	0	17,783	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	14,603	0	4,016	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	59,353	0	8,492	112,431	90.00
91.00	09100	EMERGENCY	0	191,039	0	41,276	644,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,678	878,933	894,681	263,458	2,115,301	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	42,358	0	4,403	0	192.00
192.02	19202	MOB	0	102,608	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	43,767	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	144,678	1,067,666	894,681	267,861	2,115,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	835,913					14.00
15.00	01500	PHARMACY	20,197	1,989,984				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	97,448	5,809	0	7,643,407	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	165,145	2,481	0	2,547,242	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,275	122	0	947,571	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	54	77	0	254,543	0	55.00
56.00	05600	RADIOISOTOPE	15,561	1,339	0	319,450	0	56.00
57.00	05700	CT SCAN	4,938	2,458	0	815,644	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,834	971	0	687,195	0	58.00
60.00	06000	LABORATORY	1,860	0	0	2,570,150	0	60.00
66.00	06600	PHYSICAL THERAPY	5,920	0	0	1,124,807	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	307,084	0	67.00
68.00	06800	SPEECH PATHOLOGY	8	0	0	171,498	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,343	0	0	349,798	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	197,528	0	0	298,740	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,745	0	0	44,986	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	468,764	0	1,881,422	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	1,483,248	0	5,953,140	0	73.01
76.00	03160	CARDIOPULMONARY	76,143	0	0	1,490,430	0	76.00
76.97	07697	CARDIAC REHABILITATION	182	12	0	269,975	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,026	3,508	0	1,121,766	0	90.00
91.00	09100	EMERGENCY	151,442	21,195	0	5,867,892	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	835,649	1,989,984	0	34,666,740	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	264	0	0	342,677	0	192.00
192.02	19202	MOB	0	0	0	716,971	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	207,282	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	835,913	1,989,984	0	35,933,670	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
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 - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,643,407		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,547,242		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	947,571		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	254,543		55.00
56.00	05600	RADIOISOTOPE	319,450		56.00
57.00	05700	CT SCAN	815,644		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	687,195		58.00
60.00	06000	LABORATORY	2,570,150		60.00
66.00	06600	PHYSICAL THERAPY	1,124,807		66.00
67.00	06700	OCCUPATIONAL THERAPY	307,084		67.00
68.00	06800	SPEECH PATHOLOGY	171,498		68.00
69.00	06900	ELECTROCARDIOLOGY	349,798		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	298,740		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,986		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,881,422		73.00
73.01	07301	ONCOLOGY DRUGS	5,953,140		73.01
76.00	03160	CARDIOPULMONARY	1,490,430		76.00
76.97	07697	CARDIAC REHABILITATION	269,975		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,121,766		90.00
91.00	09100	EMERGENCY	5,867,892		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,666,740		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	342,677		192.00
192.02	19202	MOB	716,971		192.02
192.03	19203	ARNETT SURGERY OFFICE	207,282		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	35,933,670		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	289,747	5,351	113,411	89,556	498,065	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	8,044	631,640	0	639,684	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	4,376	0	100,321	104,697	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	259	20,340	0	20,599	8.00
9.00	00900	HOUSEKEEPING	0	864	62,321	1,604	64,789	9.00
10.00	01000	DIETARY	0	2,228	0	51,082	53,310	10.00
11.00	01100	CAFETERIA	0	692	0	15,859	16,551	11.00
13.00	01300	NURSING ADMINISTRATION	0	837	33,305	9,471	43,613	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,290	179,780	0	182,070	14.00
15.00	01500	PHARMACY	0	978	76,780	0	77,758	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,933	387,323	0	392,256	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,142	325,195	0	329,337	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,568	123,147	0	124,715	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	322	25,304	0	25,626	55.00
56.00	05600	RADIOISOTOPE	0	222	17,448	0	17,670	56.00
57.00	05700	CT SCAN	0	303	23,810	0	24,113	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	428	33,594	0	34,022	58.00
60.00	06000	LABORATORY	0	1,423	111,772	0	113,195	60.00
66.00	06600	PHYSICAL THERAPY	0	1,379	108,302	0	109,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	110	8,628	0	8,738	67.00
68.00	06800	SPEECH PATHOLOGY	0	52	4,049	0	4,101	68.00
69.00	06900	ELECTROCARDIOLOGY	0	328	25,738	0	26,066	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	648	50,898	0	51,546	76.00
76.97	07697	CARDIAC REHABILITATION	0	786	0	18,013	18,799	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,138	167,875	0	170,013	90.00
91.00	09100	EMERGENCY	0	3,067	240,800	0	243,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	289,747	47,768	2,771,460	285,906	3,394,881	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,830	0	41,964	43,794	192.00
192.02	19202	MOB	0	6,792	0	155,710	162,502	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	1,808	0	41,443	43,251	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	289,747	58,198	2,771,460	525,023	3,644,428	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	498,065				5.00
7.00	00700	OPERATION OF PLANT	0	10,557	10,557			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	43,538	1,610	684,832		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	8,178	874	0	113,749	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,500	52	6,874	0	8.00
9.00	00900	HOUSEKEEPING	0	13,194	173	21,061	544	9.00
10.00	01000	DIETARY	0	10,132	445	0	17,337	10.00
11.00	01100	CAFETERIA	0	3,009	138	0	5,383	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,735	167	11,256	3,214	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,978	457	60,757	0	14.00
15.00	01500	PHARMACY	0	25,062	195	25,948	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	60,500	985	130,897	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,253	827	109,901	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,099	313	41,618	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,800	64	8,552	0	55.00
56.00	05600	RADIOISOTOPE	0	3,596	44	5,897	0	56.00
57.00	05700	CT SCAN	0	10,258	61	8,047	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,358	85	11,353	0	58.00
60.00	06000	LABORATORY	0	32,099	284	37,774	0	60.00
66.00	06600	PHYSICAL THERAPY	0	12,206	276	36,601	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,941	22	2,916	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,227	10	1,368	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,630	65	8,698	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,403	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	211	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,580	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	61,967	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	17,849	129	17,201	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,838	157	0	6,113	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,223	427	56,734	0	90.00
91.00	09100	EMERGENCY	0	60,806	613	81,379	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	491,727	8,473	684,832	32,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,599	366	0	14,243	192.00
192.02	19202	MOB	0	2,953	1,357	0	52,849	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	786	361	0	14,066	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	498,065	10,557	684,832	113,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,025					8.00
9.00	00900	HOUSEKEEPING	0	99,761				9.00
10.00	01000	DIETARY	0	2,988	84,212			10.00
11.00	01100	CAFETERIA	0	926	0	26,007		11.00
13.00	01300	NURSING ADMINISTRATION	0	439	0	2,478	88,902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	978	0	0	0	14.00
15.00	01500	PHARMACY	0	1,225	0	1,069	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,025	18,874	84,212	5,529	49,727	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,845	0	1,240	7,357	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,267	0	1,045	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	507	0	157	0	55.00
56.00	05600	RADIOISOTOPE	0	746	0	378	0	56.00
57.00	05700	CT SCAN	0	1,017	0	1,419	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,436	0	566	0	58.00
60.00	06000	LABORATORY	0	2,661	0	2,304	0	60.00
66.00	06600	PHYSICAL THERAPY	0	2,917	0	1,269	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	231	0	470	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	108	0	235	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,556	0	470	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	1,644	0	1,727	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,365	0	390	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,546	0	825	4,725	90.00
91.00	09100	EMERGENCY	0	17,850	0	4,008	27,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,025	82,126	84,212	25,579	88,902	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,958	0	428	0	192.00
192.02	19202	MOB	0	9,587	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	4,090	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	29,025	99,761	84,212	26,007	88,902	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	251,240					14.00
15.00	01500	PHARMACY	6,070	137,327				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,289	401	0	801,695	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,636	171	0	532,567	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	984	8	0	183,049	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	16	5	0	37,727	0	55.00
56.00	05600	RADIOISOTOPE	4,677	92	0	33,100	0	56.00
57.00	05700	CT SCAN	1,484	170	0	46,569	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	551	67	0	56,438	0	58.00
60.00	06000	LABORATORY	559	0	0	188,876	0	60.00
66.00	06600	PHYSICAL THERAPY	1,779	0	0	164,729	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,318	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0	8,051	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,114	0	0	46,599	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,371	0	0	60,774	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,940	0	0	9,151	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,349	0	51,929	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	102,358	0	164,325	0	73.01
76.00	03160	CARDIOPULMONARY	22,885	0	0	112,981	0	76.00
76.97	07697	CARDIAC REHABILITATION	55	1	0	29,718	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,232	242	0	259,967	0	90.00
91.00	09100	EMERGENCY	45,517	1,463	0	482,596	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	251,161	137,327	0	3,287,159	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79	0	0	65,467	0	192.00
192.02	19202	MOB	0	0	0	229,248	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	62,554	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	251,240	137,327	0	3,644,428	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
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 - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	801,695		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	532,567		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,049		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37,727		55.00
56.00	05600	RADIOISOTOPE	33,100		56.00
57.00	05700	CT SCAN	46,569		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	56,438		58.00
60.00	06000	LABORATORY	188,876		60.00
66.00	06600	PHYSICAL THERAPY	164,729		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,318		67.00
68.00	06800	SPEECH PATHOLOGY	8,051		68.00
69.00	06900	ELECTROCARDIOLOGY	46,599		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,774		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,151		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,929		73.00
73.01	07301	ONCOLOGY DRUGS	164,325		73.01
76.00	03160	CARDIOPULMONARY	112,981		76.00
76.97	07697	CARDIAC REHABILITATION	29,718		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	259,967		90.00
91.00	09100	EMERGENCY	482,596		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,287,159		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,467		192.00
192.02	19202	MOB	229,248		192.02
192.03	19203	ARNETT SURGERY OFFICE	62,554		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,644,428		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	94,810					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	57,501				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	37,309			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	9,687,765		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,717	2,353	6,364	346,342	-8,522,891	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	455,641	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	13,105	13,105	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	7,129	0	7,129	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	422	422	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,407	1,293	114	348,729	0	9.00
10.00	01000	DIETARY	3,630	0	3,630	385,497	0	10.00
11.00	01100	CAFETERIA	1,127	0	1,127	60,681	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,364	691	673	1,029,615	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	0	0	14.00
15.00	01500	PHARMACY	1,593	1,593	0	450,977	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,036	8,036	0	2,028,645	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,747	6,747	0	406,908	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,555	2,555	0	277,305	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	525	525	0	65,614	0	55.00
56.00	05600	RADIOISOTOPE	362	362	0	138,289	0	56.00
57.00	05700	CT SCAN	494	494	0	426,350	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	697	697	0	181,132	0	58.00
60.00	06000	LABORATORY	2,319	2,319	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,247	2,247	0	446,134	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	179	0	165,273	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	94,256	0	68.00
69.00	06900	ELECTROCARDIOLOGY	534	534	0	132,580	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,056	1,056	0	601,513	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,280	0	1,280	101,674	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,483	3,483	0	209,580	0	90.00
91.00	09100	EMERGENCY	4,996	4,996	0	1,267,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,818	57,501	20,317	9,619,806	-8,522,891	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,982	0	2,982	67,959	0	192.00
192.02	19202	MOB	11,065	0	11,065	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	2,945	0	2,945	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	58,198	2,771,460	525,023	1,764,948		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.613838	48.198466	14.072288	0.182183		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,410,779					5.00
7.00	00700	OPERATION OF PLANT	581,006	86,093				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	2,396,174	13,105	42,043			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	450,100	7,129	0	23,816		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	82,576	422	422	0	3,328	8.00
9.00	00900	HOUSEKEEPING	726,140	1,407	1,293	114	0	9.00
10.00	01000	DIETARY	557,647	3,630	0	3,630	0	10.00
11.00	01100	CAFETERIA	165,591	1,127	0	1,127	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,526,412	1,364	691	673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	384,064	3,730	3,730	0	0	14.00
15.00	01500	PHARMACY	1,379,296	1,593	1,593	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,329,675	8,036	8,036	0	3,328	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,114,648	6,747	6,747	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	500,787	2,555	2,555	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	154,127	525	525	0	0	55.00
56.00	05600	RADIOISOTOPE	197,891	362	362	0	0	56.00
57.00	05700	CT SCAN	564,564	494	494	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	459,996	697	697	0	0	58.00
60.00	06000	LABORATORY	1,766,606	2,319	2,319	0	0	60.00
66.00	06600	PHYSICAL THERAPY	671,773	2,247	2,247	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216,881	179	179	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	122,559	84	84	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,758	534	534	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,206	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,626	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,598	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	3,409,704	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	982,323	1,056	1,056	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	156,176	1,280	0	1,280	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	452,583	3,483	3,483	0	0	90.00
91.00	09100	EMERGENCY	3,346,516	4,996	4,996	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,062,003	69,101	42,043	6,824	3,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143,023	2,982	0	2,982	0	192.00
192.02	19202	MOB	162,502	11,065	0	11,065	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	43,251	2,945	0	2,945	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,522,891	761,659	3,257,162	653,120	144,678	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.310932	8.846933	77.472159	27.423581	43.472957	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	498,065	10,557	684,832	113,749	29,025	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.018170	0.122623	16.288847	4.776159	8.721454	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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			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 - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
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 - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	25,004					9.00
10.00	01000	DIETARY	749	3,328				10.00
11.00	01100	CAFETERIA	232	0	11,071			11.00
13.00	01300	NURSING ADMINISTRATION	110	0	1,055	74,655		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	245	0	0	0	326,722	14.00
15.00	01500	PHARMACY	307	0	455	0	7,894	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,731	3,328	2,354	41,758	38,088	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,470	0	528	6,178	64,548	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,320	0	445	0	1,280	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	127	0	67	0	21	55.00
56.00	05600	RADIOISOTOPE	187	0	161	0	6,082	56.00
57.00	05700	CT SCAN	255	0	604	0	1,930	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	360	0	241	0	717	58.00
60.00	06000	LABORATORY	667	0	981	0	727	60.00
66.00	06600	PHYSICAL THERAPY	731	0	540	0	2,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	58	0	200	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	27	0	100	0	3	68.00
69.00	06900	ELECTROCARDIOLOGY	390	0	200	0	7,951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	77,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,626	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	412	0	735	0	29,761	76.00
76.97	07697	CARDIAC REHABILITATION	342	0	166	0	71	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,390	0	351	3,968	17,208	90.00
91.00	09100	EMERGENCY	4,474	0	1,706	22,751	59,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,584	3,328	10,889	74,655	326,619	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	992	0	182	0	103	192.00
192.02	19202	MOB	2,403	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	1,025	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,067,666	894,681	267,861	2,115,301	835,913	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.699808	268.834435	24.194833	28.334351	2.558484	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	99,761	84,212	26,007	88,902	251,240	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.989802	25.304087	2.349110	1.190838	0.768972	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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/26/2022 3:45 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
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 - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
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	4,574,592			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	13,353	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,704	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	178	0		55.00
56.00	05600	RADIOISOTOPE	3,078	0		56.00
57.00	05700	CT SCAN	5,650	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,232	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,598	0		73.00
73.01	07301	ONCOLOGY DRUGS	3,409,704	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	28	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	8,064	0		90.00
91.00	09100	EMERGENCY	48,723	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,574,592	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,989,984	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.435008	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	137,327	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.030020	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:45 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	7,643,407		7,643,407	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,547,242		2,547,242	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	947,571		947,571	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	254,543		254,543	0	0	55.00
56.00	05600	RADIOISOTOPE	319,450		319,450	0	0	56.00
57.00	05700	CT SCAN	815,644		815,644	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	687,195		687,195	0	0	58.00
60.00	06000	LABORATORY	2,570,150		2,570,150	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,124,807	0	1,124,807	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,084	0	307,084	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	171,498	0	171,498	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	349,798		349,798	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	298,740		298,740	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,986		44,986	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,881,422		1,881,422	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	5,953,140		5,953,140	0	0	73.01
76.00	03160	CARDIOPULMONARY	1,490,430		1,490,430	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	269,975		269,975	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,121,766		1,121,766	0	0	90.00
91.00	09100	EMERGENCY	5,867,892		5,867,892	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,210,414		1,210,414		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	35,877,154	0	35,877,154	0	0	200.00
201.00		Less Observation Beds	1,210,414		1,210,414		0	201.00
202.00		Total (see instructions)	34,666,740	0	34,666,740	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:45 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,843,424		6,843,424			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,136,058	8,136,058	0.313081	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,297	6,291,651	6,413,948	0.147736	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,266	441,939	459,205	0.554312	0.000000	55.00
56.00	05600	RADIOISOTOPE	260,982	2,583,021	2,844,003	0.112324	0.000000	56.00
57.00	05700	CT SCAN	498,679	7,359,717	7,858,396	0.103793	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	102,077	1,778,498	1,880,575	0.365417	0.000000	58.00
60.00	06000	LABORATORY	1,421,744	6,777,967	8,199,711	0.313444	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	648,109	1,613,422	2,261,531	0.497365	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	559,798	210,542	770,340	0.398634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,548	237,455	306,003	0.560445	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,340,505	1,340,505	0.260945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,903	402,969	427,872	0.698199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	109,606	109,606	0.410434	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,719,866	3,579,433	7,299,299	0.257754	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	21,476,719	21,476,719	0.277190	0.000000	73.01
76.00	03160	CARDIOPULMONARY	1,507,693	3,190,822	4,698,515	0.317213	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,607,599	1,607,599	0.167937	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,157,767	6,157,767	0.182171	0.000000	90.00
91.00	09100	EMERGENCY	967,164	29,483,540	30,450,704	0.192701	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,680	2,519,331	2,527,011	0.478990	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	16,770,230	105,298,561	122,068,791			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,770,230	105,298,561	122,068,791			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:45 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	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	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:45 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	7,643,407		7,643,407	0	7,643,407	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,547,242		2,547,242	0	2,547,242	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	947,571		947,571	0	947,571	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	254,543		254,543	0	254,543	55.00
56.00	05600	RADIOISOTOPE	319,450		319,450	0	319,450	56.00
57.00	05700	CT SCAN	815,644		815,644	0	815,644	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	687,195		687,195	0	687,195	58.00
60.00	06000	LABORATORY	2,570,150		2,570,150	0	2,570,150	60.00
66.00	06600	PHYSICAL THERAPY	1,124,807	0	1,124,807	0	1,124,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	307,084	0	307,084	0	307,084	67.00
68.00	06800	SPEECH PATHOLOGY	171,498	0	171,498	0	171,498	68.00
69.00	06900	ELECTROCARDIOLOGY	349,798		349,798	0	349,798	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	298,740		298,740	0	298,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,986		44,986	0	44,986	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,881,422		1,881,422	0	1,881,422	73.00
73.01	07301	ONCOLOGY DRUGS	5,953,140		5,953,140	0	5,953,140	73.01
76.00	03160	CARDIOPULMONARY	1,490,430		1,490,430	0	1,490,430	76.00
76.97	07697	CARDIAC REHABILITATION	269,975		269,975	0	269,975	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,121,766		1,121,766	0	1,121,766	90.00
91.00	09100	EMERGENCY	5,867,892		5,867,892	0	5,867,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,210,414		1,210,414		1,210,414	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	35,877,154	0	35,877,154	0	35,877,154	200.00
201.00		Less Observation Beds	1,210,414		1,210,414		1,210,414	201.00
202.00		Total (see instructions)	34,666,740	0	34,666,740	0	34,666,740	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:45 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	6,843,424		6,843,424			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,136,058	8,136,058	0.313081	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,297	6,291,651	6,413,948	0.147736	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,266	441,939	459,205	0.554312	0.000000	55.00
56.00	05600	RADIOISOTOPE	260,982	2,583,021	2,844,003	0.112324	0.000000	56.00
57.00	05700	CT SCAN	498,679	7,359,717	7,858,396	0.103793	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	102,077	1,778,498	1,880,575	0.365417	0.000000	58.00
60.00	06000	LABORATORY	1,421,744	6,777,967	8,199,711	0.313444	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	648,109	1,613,422	2,261,531	0.497365	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	559,798	210,542	770,340	0.398634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	68,548	237,455	306,003	0.560445	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,340,505	1,340,505	0.260945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,903	402,969	427,872	0.698199	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	109,606	109,606	0.410434	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,719,866	3,579,433	7,299,299	0.257754	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	21,476,719	21,476,719	0.277190	0.000000	73.01
76.00	03160	CARDIOPULMONARY	1,507,693	3,190,822	4,698,515	0.317213	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,607,599	1,607,599	0.167937	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,157,767	6,157,767	0.182171	0.000000	90.00
91.00	09100	EMERGENCY	967,164	29,483,540	30,450,704	0.192701	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,680	2,519,331	2,527,011	0.478990	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	16,770,230	105,298,561	122,068,791			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,770,230	105,298,561	122,068,791			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/26/2022 3:45 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	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	07301	ONCOLOGY DRUGS	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/26/2022 3:45 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	532,567	8,136,058	0.065458	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,049	6,413,948	0.028539	43,114	1,230	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	37,727	459,205	0.082157	0	0	55.00
56.00	05600	RADIOISOTOPE	33,100	2,844,003	0.011639	84,804	987	56.00
57.00	05700	CT SCAN	46,569	7,858,396	0.005926	129,458	767	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	56,438	1,880,575	0.030011	42,846	1,286	58.00
60.00	06000	LABORATORY	188,876	8,199,711	0.023034	494,013	11,379	60.00
66.00	06600	PHYSICAL THERAPY	164,729	2,261,531	0.072840	159,017	11,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,318	770,340	0.021183	106,676	2,260	67.00
68.00	06800	SPEECH PATHOLOGY	8,051	306,003	0.026310	32,110	845	68.00
69.00	06900	ELECTROCARDIOLOGY	46,599	1,340,505	0.034762	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,774	427,872	0.142038	11,789	1,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,151	109,606	0.083490	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,929	7,299,299	0.007114	1,057,912	7,526	73.00
73.01	07301	ONCOLOGY DRUGS	164,325	21,476,719	0.007651	0	0	73.01
76.00	03160	CARDIOPULMONARY	112,981	4,698,515	0.024046	638,106	15,344	76.00
76.97	07697	CARDIAC REHABILITATION	29,718	1,607,599	0.018486	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	259,967	6,157,767	0.042218	0	0	90.00
91.00	09100	EMERGENCY	482,596	30,450,704	0.015848	53,132	842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	126,957	2,527,011	0.050240	190	10	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	2,612,421	115,225,367		2,853,167	55,733	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 3:45 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	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	07301	ONCOLOGY DRUGS	0	0	0	0	0	73.01
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:45 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	8,136,058	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,413,948	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	459,205	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,844,003	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	7,858,396	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,880,575	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	8,199,711	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,261,531	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	770,340	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	306,003	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,340,505	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	427,872	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	109,606	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,299,299	0.000000	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	21,476,719	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	4,698,515	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,607,599	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	6,157,767	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,450,704	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,527,011	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	0	0	115,225,367		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/26/2022 3:45 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	43,114	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	84,804	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	129,458	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	42,846	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	494,013	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	159,017	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	106,676	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,110	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	11,789	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,057,912	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	638,106	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	53,132	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	190	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Total (lines 50 through 199)		2,853,167	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 3:45 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	0.313081	0	2,253,599	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147736	0	1,313,401	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.554312	0	146,949	0	0	55.00
56.00	05600	RADIOISOTOPE	0.112324	0	837,504	0	0	56.00
57.00	05700	CT SCAN	0.103793	0	2,118,236	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.365417	0	533,798	0	0	58.00
60.00	06000	LABORATORY	0.313444	0	1,877,137	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.497365	0	451,680	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.398634	0	46,635	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.560445	0	34,620	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260945	0	325,014	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.698199	0	160,267	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410434	0	36,351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257754	0	744,527	1,840	0	73.00
73.01	07301	ONCOLOGY DRUGS	0.277190	0	10,115,028	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.317213	0	1,016,229	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.167937	0	664,815	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.182171	0	2,021,566	0	0	90.00
91.00	09100	EMERGENCY	0.192701	0	6,165,782	131,307	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.478990	0	671,795	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	31,534,933	133,147	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	31,534,933	133,147	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/26/2022 3:45 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	705,559	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,037	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	81,456	0		55.00
56.00	05600	RADIOISOTOPE	94,072	0		56.00
57.00	05700	CT SCAN	219,858	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	195,059	0		58.00
60.00	06000	LABORATORY	588,377	0		60.00
66.00	06600	PHYSICAL THERAPY	224,650	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,590	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,403	0		68.00
69.00	06900	ELECTROCARDIOLOGY	84,811	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	111,898	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,920	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,905	474		73.00
73.01	07301	ONCOLOGY DRUGS	2,803,785	0		73.01
76.00	03160	CARDIOPULMONARY	322,361	0		76.00
76.97	07697	CARDIAC REHABILITATION	111,647	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	368,271	0		90.00
91.00	09100	EMERGENCY	1,188,152	25,303		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	321,783	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	7,860,594	25,777		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,860,594	25,777		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:45 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)	3,889	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,121	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)	2,560	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	380	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	388	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)	1,160	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)	380	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)	7,643,407	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)	89,667	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)	909,551	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,733,856	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)	6,733,856	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)	2,157.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,502,804	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)	2,502,804	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:45 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)	833,102	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,335,906	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)	819,884	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)	819,884	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)	561	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,157.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,210,414	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:45 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	801,695	7,643,407	0.104887	1,210,414	126,957	90.00
91.00	Nursing Program cost	0	7,643,407	0.000000	1,210,414	0	91.00
92.00	Allied health cost	0	7,643,407	0.000000	1,210,414	0	92.00
93.00	All other Medical Education	0	7,643,407	0.000000	1,210,414	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:45 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)	3,889	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,121	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)	2,560	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	380	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	388	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)	37	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,643,407	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)	89,667	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)	909,551	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,733,856	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)	6,733,856	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)	2,157.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	79,831	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)	79,831	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:45 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)	44,452	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	124,283	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)	561	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,157.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,210,414	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/26/2022 3:45 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	801,695	7,643,407	0.104887	1,210,414	126,957	90.00
91.00	Nursing Program cost	0	7,643,407	0.000000	1,210,414	0	91.00
92.00	Allied health cost	0	7,643,407	0.000000	1,210,414	0	92.00
93.00	All other Medical Education	0	7,643,407	0.000000	1,210,414	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:45 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		2,598,957		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313081	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147736	43,114	6,369	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.554312	0	0	55.00
56.00	05600	RADIOISOTOPE	0.112324	84,804	9,526	56.00
57.00	05700	CT SCAN	0.103793	129,458	13,437	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.365417	42,846	15,657	58.00
60.00	06000	LABORATORY	0.313444	494,013	154,845	60.00
66.00	06600	PHYSICAL THERAPY	0.497365	159,017	79,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.398634	106,676	42,525	67.00
68.00	06800	SPEECH PATHOLOGY	0.560445	32,110	17,996	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260945	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.698199	11,789	8,231	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410434	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257754	1,057,912	272,681	73.00
73.01	07301	ONCOLOGY DRUGS	0.277190	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.317213	638,106	202,416	76.00
76.97	07697	CARDIAC REHABILITATION	0.167937	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.182171	0	0	90.00
91.00	09100	EMERGENCY	0.192701	53,132	10,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.478990	190	91	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,853,167	833,102	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,853,167		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:45 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	0.313081	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147736	3,849	569	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.554312	0	0	55.00
56.00	05600	RADIOISOTOPE	0.112324	3,204	360	56.00
57.00	05700	CT SCAN	0.103793	2,503	260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.365417	0	0	58.00
60.00	06000	LABORATORY	0.313444	41,276	12,938	60.00
66.00	06600	PHYSICAL THERAPY	0.497365	174,258	86,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.398634	181,948	72,531	67.00
68.00	06800	SPEECH PATHOLOGY	0.560445	8,457	4,740	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260945	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.698199	860	600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410434	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257754	103,481	26,673	73.00
73.01	07301	ONCOLOGY DRUGS	0.277190	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.317213	75,278	23,879	76.00
76.97	07697	CARDIAC REHABILITATION	0.167937	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.182171	0	0	90.00
91.00	09100	EMERGENCY	0.192701	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.478990	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		595,114	229,220	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)		595,114		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/26/2022 3:45 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		81,516		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313081	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147736	3,494	516	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.554312	0	0	55.00
56.00	05600	RADIOISOTOPE	0.112324	3,204	360	56.00
57.00	05700	CT SCAN	0.103793	7,834	813	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.365417	1,615	590	58.00
60.00	06000	LABORATORY	0.313444	28,669	8,986	60.00
66.00	06600	PHYSICAL THERAPY	0.497365	2,701	1,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.398634	799	319	67.00
68.00	06800	SPEECH PATHOLOGY	0.560445	821	460	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260945	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.698199	146	102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.410434	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257754	44,407	11,446	73.00
73.01	07301	ONCOLOGY DRUGS	0.277190	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.317213	33,860	10,741	76.00
76.97	07697	CARDIAC REHABILITATION	0.167937	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.182171	0	0	90.00
91.00	09100	EMERGENCY	0.192701	45,540	8,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.478990	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		173,090	44,452	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)		173,090		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 3:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,886,371	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)	7,886,371	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)	7,965,235	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)	62,190	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,668,039	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)	2,235,006	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)	2,235,006	30.00
31.00	Primary payer payments	2,555	31.00
32.00	Subtotal (line 30 minus line 31)	2,232,451	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)	624,466	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	405,903	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	262,014	36.00
37.00	Subtotal (see instructions)	2,638,354	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,638,354	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	4,083,896	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)	-1,445,542	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	382,361	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: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 3:45 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		3,223,947		4,083,896	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)		3,223,947		4,083,896	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		142,769		1,445,542	6.02
7.00	Total Medicare program liability (see instructions)		3,081,178		2,638,354	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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2022 3:45 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		1,112,239		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,112,239		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		63,032		0	6.02
7.00	Total Medicare program liability (see instructions)		1,049,207		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: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 3:45 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: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/26/2022 3:45 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)	828,083	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)	231,512	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	380	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,059,595	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,059,595	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,059,595	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,388	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,049,207	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,049,207	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,112,239	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)	-63,032	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	50,290	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: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 3:45 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,335,906	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)	3,335,906	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,369,265	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)	3,369,265	19.00
20.00	Deductibles (exclude professional component)	318,756	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,050,509	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,050,509	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,183	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	30,669	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,764	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,081,178	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)	3,081,178	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	3,223,947	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)	-142,769	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	159,884	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/26/2022 3:45 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	38,894,549	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	4,857,476	0	0	0	4.00
5.00	Other receivable	341,043	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	586,764	0	0	0	7.00
8.00	Prepaid expenses	167,309	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)	44,847,141	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	122,178	0	0	0	13.00
14.00	Accumulated depreciation	-115,181	0	0	0	14.00
15.00	Buildings	30,277,094	0	0	0	15.00
16.00	Accumulated depreciation	-8,355,900	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,481,024	0	0	0	23.00
24.00	Accumulated depreciation	-7,127,493	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)	28,254,501	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	188,509	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	141,200	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	329,709	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,431,351	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,505,086	0	0	0	37.00
38.00	Salaries, wages, and fees payable	618,808	0	0	0	38.00
39.00	Payroll taxes payable	47,142	0	0	0	39.00
40.00	Notes and loans payable (short term)	650,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	2,304,555				42.00
43.00	Due to other funds	4,979,055	0	0	0	43.00
44.00	Other current liabilities	11,042	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,115,688	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,335,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	29,965	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,364,965	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,480,653	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,950,698				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)	43,950,698	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,431,351	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/26/2022 3:45 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		34,185,297		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,718,037				2.00
3.00	Total (sum of line 1 and line 2)		43,903,334		0		3.00
4.00	NET INTERCOMPANY TRANSACTIONS	47,363		0		0	4.00
5.00	ROUNDING	1		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		47,364		0		10.00
11.00	Subtotal (line 3 plus line 10)		43,950,698		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)		43,950,698		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	NET INTERCOMPANY TRANSACTIONS		0			4.00
5.00	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/26/2022 3:45 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,166,738		6,166,738	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	676,686		676,686	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)	6,843,424		6,843,424	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)	6,843,424		6,843,424	17.00
18.00	Ancillary services	8,951,962	67,137,923	76,089,885	18.00
19.00	Outpatient services	974,844	38,160,638	39,135,482	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,770,230	105,298,561	122,068,791	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,730,470		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)		34,730,470		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/26/2022 3:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	122,068,791	1.00
2.00	Less contractual allowances and discounts on patients' accounts	82,952,687	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,116,104	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,730,470	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,385,634	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	751,302	24.00
24.50	COVID-19 PHE Funding	4,581,101	24.50
25.00	Total other income (sum of lines 6-24)	5,332,403	25.00
26.00	Total (line 5 plus line 25)	9,718,037	26.00
27.00	OTHER EXPENSES	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)	9,718,037	29.00