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: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/30/2022 4:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2022 Time: 4:01 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 LAPORTE HOSPITAL (15-0006) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	286,842	-3,934	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	286,842	-3,934	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2022 4:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: STATE & MADISON STREETS	PO Box: 250			1.00
2.00	City: LAPORTE	State: IN	Zip Code: 46350-	County: LA PORTE	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	LAPORTE HOSPITAL	150006	33140	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	LAPORTE HOSPITAL COMPANY LLC	15U006	33140		03/01/2020	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2022 4:01 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.	715	260	0	16	4,576	149	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 4:01 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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 4:01 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)	N		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)	N	N	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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 4:01 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2022 4:01 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.	Y			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:	57,237	72,938	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2022 4:01 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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2022 4:01 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.	Y	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	03/08/2022	Y	03/08/2022	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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2022 4:01 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2020	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/30/2022 4:01 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.	REVENUE MANAGER		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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2022 4:01 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	60	21,900	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		74	27,010	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2022 4:01 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)	7,211	610	18,586			1.00
2.00	HMO and other (see instructions)	5,395	3,913				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,211	610	18,586			7.00
8.00	INTENSIVE CARE UNIT	1,169	33	3,432			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		1,011	1,326			13.00
14.00	Total (see instructions)	8,380	1,654	23,344	0.00	580.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	580.11	27.00
28.00	Observation Bed Days		0	1,355			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			152			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	149	219			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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2022 4:01 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	1,636	1,168	4,599	1.00
2.00	HMO and other (see instructions)			902	0		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	1,636	1,168	4,599	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2022 4:01 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	41,384,614	0	41,384,614	1,206,625.00	34.30	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		259,532	0	259,532	1,000.00	259.53	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		249,203	0	249,203	7,236.00	34.44	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,741,236	0	4,741,236	57,667.00	82.22	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		46,314	0	46,314	237.00	195.42	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,952,460	0	3,952,460	140,269.00	28.18	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,561,427	0	9,561,427			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		58,854	0	58,854			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		18,559	0	18,559			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,052,584	0	1,052,584			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2022 4:01 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	263,957	0	263,957	9,022.00	29.26	26.00
27.00	Administrative & General	5.00	6,488,200	-318,686	6,169,514	215,952.00	28.57	27.00
28.00	Administrative & General under contract (see inst.)		56,869	0	56,869	655.00	86.82	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,069,285	0	1,069,285	43,080.00	24.82	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		707,803	0	707,803	43,477.00	16.28	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,085,826	0	1,085,826	60,753.00	17.87	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,266,660	318,686	2,585,346	55,075.00	46.94	38.00
39.00	Central Services and Supply	14.00	547,367	0	547,367	23,957.00	22.85	39.00
40.00	Pharmacy	15.00	1,359,161	0	1,359,161	33,126.00	41.03	40.00
41.00	Medical Records & Medical Records Library	16.00	426,818	0	426,818	18,273.00	23.36	41.00
42.00	Social Service	17.00	511,298	0	511,298	13,019.00	39.27	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2022 4:01 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		43,235,112	0	43,235,112	1,311,510.00	32.97	1.00
2.00	Excluded area salaries (see instructions)		249,203	0	249,203	7,236.00	34.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)		42,985,909	0	42,985,909	1,304,274.00	32.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,740,010	0	8,740,010	198,173.00	44.10	4.00
5.00	Subtotal wage-related costs (see inst.)		10,632,570	0	10,632,570	0.00	24.74	5.00
6.00	Total (sum of lines 3 thru 5)		62,358,489	0	62,358,489	1,502,447.00	41.50	6.00
7.00	Total overhead cost (see instructions)		14,783,244	0	14,783,244	516,389.00	28.63	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2022 4:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	926,643	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,824,377	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	103,080	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,793	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-265	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	96,145	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	561,217	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,437,439	17.00
18.00	Medicare Taxes - Employers Portion Only	570,046	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	86,365	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,638,840	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2022 4:01 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,741,236	9,638,840	1.00
2.00	Hospital	4,741,236	9,638,840	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet S-10 | Date/Time Prepared: 5/30/2022 4:01 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)	0.184366	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	31,015,284	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	150,747,844	6.00
7.00	Medicaid cost (line 1 times line 6)	27,792,777	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,363,491	0	5,363,491	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	988,845	0	988,845	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,208	0	1,208	22.00
23.00	Cost of charity care (line 21 minus line 22)	987,637	0	987,637	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)	9,429,987	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	261,856	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	402,856	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,027,131	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,805,296	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,792,933	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,792,933	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/30/2022 4:01 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		295,947	295,947	4,065,524	4,361,471	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,308,212	12,308,212	641,122	12,949,334	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	263,957	163,291	427,248	6,594,994	7,022,242	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,488,200	43,974,299	50,462,499	-11,996,492	38,466,007	5.00
7.00	00700	OPERATION OF PLANT	1,069,285	4,654,646	5,723,931	3,374,164	9,098,095	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	490,902	490,902	0	490,902	8.00
9.00	00900	HOUSEKEEPING	0	1,852,182	1,852,182	-10,272	1,841,910	9.00
10.00	01000	DIETARY	0	2,545,319	2,545,319	-1,452,704	1,092,615	10.00
11.00	01100	CAFETERIA	0	0	0	1,419,703	1,419,703	11.00
13.00	01300	NURSING ADMINISTRATION	2,266,660	451,755	2,718,415	282,175	3,000,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	547,367	6,487,497	7,034,864	-5,932,058	1,102,806	14.00
15.00	01500	PHARMACY	1,359,161	11,836,057	13,195,218	-11,633,556	1,561,662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	426,818	698,086	1,124,904	-1,919	1,122,985	16.00
17.00	01700	SOCIAL SERVICE	511,298	210,848	722,146	-277	721,869	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,845,058	5,268,776	11,113,834	806,845	11,920,679	30.00
31.00	03100	INTENSIVE CARE UNIT	2,457,054	2,168,257	4,625,311	-27,277	4,598,034	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	493,043	493,043	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,179,637	4,670,322	6,849,959	-1,514,226	5,335,733	50.00
51.00	05100	RECOVERY ROOM	1,451,801	278,919	1,730,720	-3,997	1,726,723	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,736,295	389,438	2,125,733	-1,397,167	728,566	52.00
53.00	05300	ANESTHESIOLOGY	48,561	1,868,395	1,916,956	-21,826	1,895,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,709,465	978,368	2,687,833	-696,135	1,991,698	54.00
54.01	05401	ULTRASOUND	365,773	57,119	422,892	-8,540	414,352	54.01
56.00	05600	RADIOISOTOPE	309,333	240,988	550,321	-8,154	542,167	56.00
57.00	05700	CT SCAN	564,221	167,606	731,827	-46,541	685,286	57.00
58.00	05800	MRI	183,051	47,162	230,213	-12,220	217,993	58.00
60.00	06000	LABORATORY	2,283,691	3,051,342	5,335,033	-868,756	4,466,277	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	683,050	683,050	62.00
65.00	06500	RESPIRATORY THERAPY	1,027,156	187,720	1,214,876	-17,933	1,196,943	65.00
66.00	06600	PHYSICAL THERAPY	1,834,872	338,580	2,173,452	-52,176	2,121,276	66.00
67.00	06700	OCCUPATIONAL THERAPY	611,207	70,119	681,326	-756	680,570	67.00
68.00	06800	SPEECH PATHOLOGY	498,224	114,104	612,328	-884	611,444	68.00
69.00	06900	ELECTROCARDIOLOGY	2,879,169	1,496,168	4,375,337	-481,516	3,893,821	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	781,423	781,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,100,555	5,100,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,252,094	11,252,094	73.00
74.00	07400	RENAL DIALYSIS	0	464,288	464,288	0	464,288	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	294,198	65,331	359,529	-14,626	344,903	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,691	786,866	788,557	-4,674	783,883	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,769,677	3,769,677	0	3,769,677	90.00
91.00	09100	EMERGENCY	1,922,208	1,351,700	3,273,908	-21,235	3,252,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,135,411	113,800,286	154,935,697	-731,225	154,204,472	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	156,368	-620,417	-464,049	731,225	267,176	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	92,835	68,700	161,535	0	161,535	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	41,384,614	113,248,569	154,633,183	0	154,633,183	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A | Date/Time Prepared: 5/30/2022 4:01 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	141,558	4,503,029		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-227,292	12,722,042		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,058	7,018,184		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,022,525	30,443,482		5.00
7.00	00700	OPERATION OF PLANT	-41,404	9,056,691		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	490,902		8.00
9.00	00900	HOUSEKEEPING	0	1,841,910		9.00
10.00	01000	DIETARY	0	1,092,615		10.00
11.00	01100	CAFETERIA	0	1,419,703		11.00
13.00	01300	NURSING ADMINISTRATION	-117,181	2,883,409		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,102,806		14.00
15.00	01500	PHARMACY	0	1,561,662		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-15,955	1,107,030		16.00
17.00	01700	SOCIAL SERVICE	0	721,869		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,600,669	10,320,010		30.00
31.00	03100	INTENSIVE CARE UNIT	-716,198	3,881,836		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	493,043		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,405,832	3,929,901		50.00
51.00	05100	RECOVERY ROOM	0	1,726,723		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-56,816	671,750		52.00
53.00	05300	ANESTHESIOLOGY	-1,693,000	202,130		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-45,840	1,945,858		54.00
54.01	05401	ULTRASOUND	0	414,352		54.01
56.00	05600	RADIOISOTOPE	0	542,167		56.00
57.00	05700	CT SCAN	0	685,286		57.00
58.00	05800	MRI	0	217,993		58.00
60.00	06000	LABORATORY	0	4,466,277		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	683,050		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,196,943		65.00
66.00	06600	PHYSICAL THERAPY	0	2,121,276		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	680,570		67.00
68.00	06800	SPEECH PATHOLOGY	0	611,444		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,893,821		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-31,569	749,854		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,100,555		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-10,042	11,242,052		73.00
74.00	07400	RENAL DIALYSIS	0	464,288		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	344,903		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	6,789	790,672		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-3,769,677	0		90.00
91.00	09100	EMERGENCY	-117,805	3,134,868		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,727,516	136,476,956		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	267,176		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	161,535		194.00
194.01	07951	MARKETING	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,727,516	136,905,667		200.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/30/2022 4:01 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,596,149	1.00
	0		0	6,596,149	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,101,520	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	614,248	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	3,715,768	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	278,574	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,373,422	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,874	3.00
	0		0	2,678,870	
	D - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	2,172,840	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	0		0	2,172,840	
	E - CHIEF NURSING OFFICER COSTS				
1.00	NURSING ADMINISTRATION	13.00	318,686	0	1.00
	0		318,686	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	781,423	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,100,555	2.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/30/2022 4:01 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	5,881,978		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,252,094		1.00
	0		0	11,252,094		
	H - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	740,178	157,288		1.00
2.00	NURSERY	43.00	406,346	86,697		2.00
	0		1,146,524	243,985		
	I - CAFETERIA RECLASSIFICATION					
1.00	CAFETERIA	11.00	0	1,419,703		1.00
	0		0	1,419,703		
	J - NONCAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	521,190		1.00
2.00	WOUND CARE	76.03	0	42		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	TOTALS		0	521,232		
	K - BLOOD BANK RECLASSIFICATION					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	145,048	538,002		1.00
	TOTALS		145,048	538,002		
	L - MOB OVERHEAD					
1.00	OPERATION OF PLANT	7.00	0	805,622		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	882,370		2.00
	TOTALS		0	1,687,992		
500.00	Grand Total: Increases		1,610,258	36,708,613		500.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/30/2022 4:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,596,149	0		1.00
	0		0	6,596,149			
	B - RENTAL AND LEASE EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,070,466	10		2.00
3.00	OPERATION OF PLANT	7.00	0	125,488	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,307	0		4.00
5.00	DIETARY	10.00	0	274	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	24,861	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,178	0		7.00
8.00	PHARMACY	15.00	0	296,609	0		8.00
9.00	SOCIAL SERVICE	17.00	0	2	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	62,326	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	17,562	0		11.00
12.00	OPERATING ROOM	50.00	0	788,604	0		12.00
13.00	RECOVERY ROOM	51.00	0	680	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,464	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	99,408	0		15.00
16.00	CT SCAN	57.00	0	10,813	0		16.00
17.00	LABORATORY	60.00	0	77,473	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	8,308	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	424	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	6	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	113,249	0		21.00
22.00	SLEEP LAB	76.01	0	5,833	0		22.00
23.00	WOUND CARE	76.03	0	883	0		23.00
24.00	EMERGENCY	91.00	0	2,510	0		24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5	0		25.00
	0		0	3,715,768			
	C - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,678,870	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	2,678,870			
	D - REPAIRS AND MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	362	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	246,736	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,323	0		3.00
4.00	DIETARY	10.00	0	32,727	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,074	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	72,532	0		6.00
7.00	PHARMACY	15.00	0	83,764	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	61	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	11,971	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5,887	0		10.00
11.00	OPERATING ROOM	50.00	0	366,702	0		11.00
12.00	RECOVERY ROOM	51.00	0	1,532	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,918	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	18,421	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	584,627	0		15.00
16.00	ULTRASOUND	54.01	0	8,540	0		16.00
17.00	RADIOISOTOPE	56.00	0	8,154	0		17.00
18.00	CT SCAN	57.00	0	34,600	0		18.00
19.00	MRI	58.00	0	11,773	0		19.00
20.00	LABORATORY	60.00	0	96,448	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	9,201	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	46,120	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	520	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	519	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	349,175	0		25.00
26.00	SLEEP LAB	76.01	0	8,257	0		26.00
27.00	WOUND CARE	76.03	0	3,833	0		27.00
28.00	EMERGENCY	91.00	0	12,502	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	149,561	0		29.00
	0		0	2,172,840			
	E - CHIEF NURSING OFFICER COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	318,686	0	0		1.00
	0		318,686	0			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,812,540	0		1.00
2.00	OPERATING ROOM	50.00	0	69,438	0		2.00
	0		0	5,881,978			

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: 5/30/2022 4:01 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	11,252,094	0	1.00
	0		0	11,252,094		
	H - LABOR AND DELIVERY COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,146,524	243,985	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,146,524	243,985		
	I - CAFETERIA RECLASSIFICATION					
1.00	DIETARY	10.00	0	1,419,703	0	1.00
	0		0	1,419,703		
	J - NONCAPITALIZED EQUIPMENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	758	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	85,585	0	2.00
3.00	HOUSEKEEPING	9.00	0	6,642	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	9,576	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	39,808	0	5.00
6.00	PHARMACY	15.00	0	1,089	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,858	0	7.00
8.00	SOCIAL SERVICE	17.00	0	275	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	16,324	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	3,828	0	10.00
11.00	OPERATING ROOM	50.00	0	289,482	0	11.00
12.00	RECOVERY ROOM	51.00	0	1,785	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,276	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	3,405	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,100	0	15.00
16.00	CT SCAN	57.00	0	1,128	0	16.00
17.00	MRI	58.00	0	447	0	17.00
18.00	LABORATORY	60.00	0	11,785	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	424	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	5,632	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	236	0	21.00
22.00	SPEECH PATHOLOGY	68.00	0	359	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	19,092	0	23.00
24.00	SLEEP LAB	76.01	0	536	0	24.00
25.00	EMERGENCY	91.00	0	6,223	0	25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,579	0	26.00
	TOTALS		0	521,232		
	K - BLOOD BANK RECLASSIFICATION					
1.00	LABORATORY	60.00	145,048	538,002	0	1.00
	TOTALS		145,048	538,002		
	L - MOB OVERHEAD					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,687,992	10	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	1,687,992		
500.00	Grand Total: Decreases		1,610,258	36,708,613		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2022 4:01 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	5,512,165	0	0	0	0	1.00
2.00	Land Improvements	2,539,426	0	0	0	1,547,622	2.00
3.00	Buildings and Fixtures	50,757,653	0	0	0	41,959,776	3.00
4.00	Building Improvements	41,365,984	0	0	0	39,305,264	4.00
5.00	Fixed Equipment	26,146,830	0	0	0	21,733,536	5.00
6.00	Movable Equipment	88,149,976	5,886	0	5,886	76,959,361	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,472,034	5,886	0	5,886	181,505,559	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	214,472,034	5,886	0	5,886	181,505,559	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,512,165	0	1.00
2.00	Land Improvements	991,804	0	2.00
3.00	Buildings and Fixtures	8,797,877	0	3.00
4.00	Building Improvements	2,060,720	0	4.00
5.00	Fixed Equipment	4,413,294	0	5.00
6.00	Movable Equipment	11,196,501	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,972,361	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,972,361	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2022 4:01 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	3,305,559	-3,009,612	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,046,345	3,261,867	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,351,904	252,255	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	295,947		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,308,212		2.00
3.00	Total (sum of lines 1-2)	0	12,604,159		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2022 4:01 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	17,362,566	0	17,362,566	0.526579	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,609,796	0	15,609,796	0.473421	0	2.00
3.00	Total (sum of lines 1-2)	32,972,362	0	32,972,362	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,750,293	-1,596,084	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,463,571	3,833,010	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,213,864	2,236,926	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-303,176	278,574	2,373,422	0	4,503,029	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	398,587	26,874	0	0	12,722,042	2.00
3.00	Total (sum of lines 1-2)	95,411	305,448	2,373,422	0	17,225,071	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/30/2022 4:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,404	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-41,404	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,975,866			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,046	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-8,425,694			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	B	-31,569	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-10,042	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-15,955	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-473	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	444,734	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-582,774	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-117,181	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8 | Date/Time Prepared: 5/30/2022 4:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	TELEPHONE COMMISSION	B	-27,158	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MISC NON-PATIENT REVENUE	B	-53,456	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-479,231	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00	OTHER MISCELLANEOUS REVENUE	B	-121,674	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PATIENT TELEPHONE BENEFIT COST	A	-4,058	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MARKETING EXPENSE	A	-345,925	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MGMT FEE AND MOB GAIN/LOSS	A	2,663,393	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN RECRUITING	A	-418,795	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.04	NONALLOWABLE EXPENSE - LOBBYING	A	-73	ADMINISTRATIVE & GENERAL	5.00	0	41.04
42.00	CHARITABLE CONTRIBUTIONS	A	-33,500	ADMINISTRATIVE & GENERAL	5.00	0	42.00
45.00	LEGAL FEES	A	-19,595	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.02	PATIENT TELEPHONE DEPRECIATION	A	-13,971	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.02
45.04	ACCREDIDATION FEES	A	-10,117	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.09	PATIENT TV DEPRECIATION	A	-29,134	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.09
45.10	PATIENT PHONE WAGES	A	-17,424	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.12	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-55,124	ADMINISTRATIVE & GENERAL	5.00	0	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,727,516				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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2022 4:01 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	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	4,962	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	608	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	421,176	591,044	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	2,986,863	1,620,000	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	171,093	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	397,979	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	4,285,749	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	130,175	668,455	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	6,891,571	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	3,719,629	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	4,400	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	128,797	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2,656,713	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	468,710	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	Contract Management	0	32,400	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	42,580	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,398,605	16,824,299	5.00

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

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

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

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

6.00	B		0.00	CHS	100.00	6.00
7.00	B		0.00	PASI	100.00	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

(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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2022 4:01 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	4,962	11		4.00
4.01	608	11		4.01
4.02	-169,868	11		4.02
4.03	1,366,863	0		4.03
4.04	171,093	11		4.04
4.05	397,979	11		4.05
4.06	4,285,749	0		4.06
4.07	-538,280	0		4.07
4.08	-6,891,571	0		4.08
4.09	-3,719,629	0		4.09
4.10	-4,400	0		4.10
4.11	-128,797	0		4.11
4.12	-2,656,713	0		4.12
4.13	-468,710	0		4.13
4.14	-32,400	0		4.14
4.15	-42,580	0		4.15
5.00	-8,425,694			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	HEALTHCARE		6.00
7.00	COLLECTION UNIT		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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2022 4:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	577,864	577,864	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,600,669	1,600,669	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	716,198	716,198	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,405,832	1,405,832	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	56,816	56,816	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,693,000	1,693,000	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	44,794	44,794	0	0	0	7.00
8.00	76.03	WOUND CARE	-6,789	-6,789	0	0	0	8.00
9.00	90.00	CLINIC	3,769,677	3,769,677	0	0	0	9.00
10.00	91.00	EMERGENCY	117,805	117,805	0	0	0	10.00
200.00			9,975,866	9,975,866	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	76.03	WOUND CARE	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	577,864		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,600,669		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	716,198		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,405,832		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	56,816		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,693,000		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	44,794		7.00
8.00	76.03	WOUND CARE	0	0	0	-6,789		8.00
9.00	90.00	CLINIC	0	0	0	3,769,677		9.00
10.00	91.00	EMERGENCY	0	0	0	117,805		10.00
200.00			0	0	0	9,975,866		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,503,029	4,503,029				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,722,042		12,722,042			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,018,184	13,147	37,143	7,068,474		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,443,482	177,745	502,168	1,060,515	32,183,910	5.00
7.00	00700	OPERATION OF PLANT	9,056,691	2,815,111	7,953,309	183,806	20,008,917	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	490,902	4,595	12,983	0	508,480	8.00
9.00	00900	HOUSEKEEPING	1,841,910	16,351	46,194	0	1,904,455	9.00
10.00	01000	DIETARY	1,092,615	25,688	72,574	0	1,190,877	10.00
11.00	01100	CAFETERIA	1,419,703	16,251	45,912	0	1,481,866	11.00
13.00	01300	NURSING ADMINISTRATION	2,883,409	12,115	34,227	444,411	3,374,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,102,806	33,207	93,818	94,090	1,323,921	14.00
15.00	01500	PHARMACY	1,561,662	21,832	61,680	233,634	1,878,808	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,107,030	5,495	15,523	73,368	1,201,416	16.00
17.00	01700	SOCIAL SERVICE	721,869	4,043	11,421	87,890	825,223	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,320,010	247,656	699,682	1,131,974	12,399,322	30.00
31.00	03100	INTENSIVE CARE UNIT	3,881,836	76,498	216,123	422,358	4,596,815	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	493,043	726	2,051	69,849	565,669	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,929,901	156,845	443,123	374,671	4,904,540	50.00
51.00	05100	RECOVERY ROOM	1,726,723	15,318	43,277	249,559	2,034,877	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	671,750	101,260	286,082	101,379	1,160,471	52.00
53.00	05300	ANESTHESIOLOGY	202,130	2,451	6,924	8,347	219,852	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,945,858	150,179	424,288	293,850	2,814,175	54.00
54.01	05401	ULTRASOUND	414,352	4,609	13,021	62,875	494,857	54.01
56.00	05600	RADIOISOTOPE	542,167	7,553	21,338	53,173	624,231	56.00
57.00	05700	CT SCAN	685,286	7,599	21,469	96,987	811,341	57.00
58.00	05800	MRI	217,993	8,971	25,345	31,466	283,775	58.00
60.00	06000	LABORATORY	4,466,277	51,769	146,259	367,624	5,031,929	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	683,050	2,664	7,526	24,933	718,173	62.00
65.00	06500	RESPIRATORY THERAPY	1,196,943	7,652	21,620	176,564	1,402,779	65.00
66.00	06600	PHYSICAL THERAPY	2,121,276	133,455	377,040	315,407	2,947,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	680,570	36,071	101,909	105,064	923,614	67.00
68.00	06800	SPEECH PATHOLOGY	611,444	24,329	68,736	85,643	790,152	68.00
69.00	06900	ELECTROCARDIOLOGY	3,893,821	142,966	403,910	494,918	4,935,615	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749,854	0	0	0	749,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,100,555	0	0	0	5,100,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,242,052	0	0	0	11,242,052	73.00
74.00	07400	RENAL DIALYSIS	464,288	1,772	5,005	0	471,065	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	344,903	50,344	142,232	50,571	588,050	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	790,672	30,850	87,157	291	908,970	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,134,868	90,957	256,974	330,420	3,813,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,476,956	4,498,074	12,708,043	7,025,637	136,415,165	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,955	13,999	0	18,954	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	267,176	0	0	26,879	294,055	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	161,535	0	0	15,958	177,493	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	136,905,667	4,503,029	12,722,042	7,068,474	136,905,667	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,183,910					5.00
7.00	00700	OPERATION OF PLANT	6,149,284	26,158,201				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	156,270	80,299	745,049			8.00
9.00	00900	HOUSEKEEPING	585,292	285,701	0	2,775,448		9.00
10.00	01000	DIETARY	365,990	448,859	0	48,301	2,054,027	10.00
11.00	01100	CAFETERIA	455,419	283,955	0	30,556	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,036,974	211,686	0	22,779	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	406,878	580,246	0	62,439	0	14.00
15.00	01500	PHARMACY	577,410	381,477	0	41,050	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,229	96,009	0	10,331	0	16.00
17.00	01700	SOCIAL SERVICE	253,614	70,640	0	7,601	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,810,659	4,327,406	326,777	465,664	1,356,726	30.00
31.00	03100	INTENSIVE CARE UNIT	1,412,730	1,336,684	60,110	143,838	151,195	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	173,846	12,685	0	1,365	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,507,302	2,740,632	98,110	294,914	0	50.00
51.00	05100	RECOVERY ROOM	625,375	267,663	26,264	28,803	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	356,645	1,769,366	0	190,398	0	52.00
53.00	05300	ANESTHESIOLOGY	67,567	42,826	0	4,608	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	864,875	2,624,141	62,627	282,379	0	54.00
54.01	05401	ULTRASOUND	152,083	80,532	0	8,666	0	54.01
56.00	05600	RADIOISOTOPE	191,844	131,969	0	14,201	0	56.00
57.00	05700	CT SCAN	249,348	132,784	0	14,289	0	57.00
58.00	05800	MRI	87,212	156,757	0	16,868	0	58.00
60.00	06000	LABORATORY	1,546,453	904,583	0	97,340	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	220,715	46,550	0	5,009	0	62.00
65.00	06500	RESPIRATORY THERAPY	431,113	133,715	0	14,389	0	65.00
66.00	06600	PHYSICAL THERAPY	905,750	2,331,923	0	250,934	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	283,852	630,287	0	67,824	0	67.00
68.00	06800	SPEECH PATHOLOGY	242,836	425,118	0	45,746	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,516,853	2,498,107	26,626	268,816	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	230,451	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,567,543	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,454,997	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	144,771	30,956	0	3,331	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	180,724	879,679	1,407	94,661	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	279,352	539,049	0	58,006	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,171,909	1,589,334	143,128	171,025	110,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,033,165	26,071,618	745,049	2,766,131	1,618,112	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,825	86,583	0	9,317	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	90,371	0	0	0	435,505	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	54,549	0	0	0	410	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	32,183,910	26,158,201	745,049	2,775,448	2,054,027	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,251,796					11.00
13.00	01300	NURSING ADMINISTRATION	132,144	4,777,745				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,489	0	2,430,973			14.00
15.00	01500	PHARMACY	79,496	0	9,220	2,967,461		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,865	0	1,416	0	1,722,266	16.00
17.00	01700	SOCIAL SERVICE	31,240	117	326	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	465,797	1,642,266	115,432	0	136,473	30.00
31.00	03100	INTENSIVE CARE UNIT	135,239	793,051	81,136	0	34,935	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	21,159	0	0	0	5,566	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,943	326,606	276,182	0	254,759	50.00
51.00	05100	RECOVERY ROOM	85,734	378,165	36,288	0	42,510	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,714	532,659	38,617	0	11,397	52.00
53.00	05300	ANESTHESIOLOGY	5,439	0	29,943	0	62,952	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,392	133,749	20,165	0	33,648	54.00
54.01	05401	ULTRASOUND	17,965	0	3,739	0	18,529	54.01
56.00	05600	RADIOISOTOPE	15,221	127	36,834	0	26,249	56.00
57.00	05700	CT SCAN	40,322	11,524	12,468	0	79,400	57.00
58.00	05800	MRI	11,378	1,442	2,803	0	27,140	58.00
60.00	06000	LABORATORY	211,591	0	270,372	0	191,916	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,033	0	105,727	0	5,970	62.00
65.00	06500	RESPIRATORY THERAPY	72,011	0	7,895	0	26,258	65.00
66.00	06600	PHYSICAL THERAPY	117,623	0	2,552	0	35,610	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,879	0	531	0	17,063	67.00
68.00	06800	SPEECH PATHOLOGY	29,493	0	678	0	11,468	68.00
69.00	06900	ELECTROCARDIOLOGY	170,121	359,004	90,642	0	137,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	116,982	0	38,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,066,499	0	77,650	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,967,461	326,165	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	10,876	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	21,858	0	3,638	0	9,830	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	250	0	20,850	0	6,521	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	112,033	567,311	78,430	0	93,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,234,429	4,746,021	2,429,365	2,967,461	1,722,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,031	31,724	1,527	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	7,336	0	81	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	2,251,796	4,777,745	2,430,973	2,967,461	1,722,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part I Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,188,761					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	946,466	25,992,988	0	25,992,988		30.00
31.00	03100	INTENSIVE CARE UNIT	174,770	8,920,503	0	8,920,503		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	67,525	847,815	0	847,815		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,561,988	0	10,561,988		50.00
51.00	05100	RECOVERY ROOM	0	3,525,679	0	3,525,679		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,104,267	0	4,104,267		52.00
53.00	05300	ANESTHESIOLOGY	0	433,187	0	433,187		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,943,151	0	6,943,151		54.00
54.01	05401	ULTRASOUND	0	776,371	0	776,371		54.01
56.00	05600	RADIOISOTOPE	0	1,040,676	0	1,040,676		56.00
57.00	05700	CT SCAN	0	1,351,476	0	1,351,476		57.00
58.00	05800	MRI	0	587,375	0	587,375		58.00
60.00	06000	LABORATORY	0	8,254,184	0	8,254,184		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,111,177	0	1,111,177		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,088,160	0	2,088,160		65.00
66.00	06600	PHYSICAL THERAPY	0	6,591,570	0	6,591,570		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,960,050	0	1,960,050		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,545,491	0	1,545,491		68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,003,425	0	10,003,425		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,135,772	0	1,135,772		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,812,247	0	7,812,247		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,990,675	0	17,990,675		73.00
74.00	07400	RENAL DIALYSIS	0	660,999	0	660,999		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	1,779,847	0	1,779,847		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	1,812,998	0	1,812,998		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	7,849,835	0	7,849,835		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,188,761	135,681,906	0	135,681,906		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	120,679	0	120,679		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	863,213	0	863,213		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	239,869	0	239,869		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,188,761	136,905,667	0	136,905,667		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,147	37,143	50,290	50,290	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	177,745	502,168	679,913	7,545	5.00
7.00	00700	OPERATION OF PLANT	0	2,815,111	7,953,309	10,768,420	1,308	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,595	12,983	17,578	0	8.00
9.00	00900	HOUSEKEEPING	0	16,351	46,194	62,545	0	9.00
10.00	01000	DIETARY	0	25,688	72,574	98,262	0	10.00
11.00	01100	CAFETERIA	0	16,251	45,912	62,163	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,115	34,227	46,342	3,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,207	93,818	127,025	669	14.00
15.00	01500	PHARMACY	0	21,832	61,680	83,512	1,662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,495	15,523	21,018	522	16.00
17.00	01700	SOCIAL SERVICE	0	4,043	11,421	15,464	625	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	247,656	699,682	947,338	8,054	30.00
31.00	03100	INTENSIVE CARE UNIT	0	76,498	216,123	292,621	3,005	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	726	2,051	2,777	497	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	156,845	443,123	599,968	2,666	50.00
51.00	05100	RECOVERY ROOM	0	15,318	43,277	58,595	1,776	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	101,260	286,082	387,342	721	52.00
53.00	05300	ANESTHESIOLOGY	0	2,451	6,924	9,375	59	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,179	424,288	574,467	2,091	54.00
54.01	05401	ULTRASOUND	0	4,609	13,021	17,630	447	54.01
56.00	05600	RADIOISOTOPE	0	7,553	21,338	28,891	378	56.00
57.00	05700	CT SCAN	0	7,599	21,469	29,068	690	57.00
58.00	05800	MRI	0	8,971	25,345	34,316	224	58.00
60.00	06000	LABORATORY	0	51,769	146,259	198,028	2,616	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,664	7,526	10,190	177	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,652	21,620	29,272	1,256	65.00
66.00	06600	PHYSICAL THERAPY	0	133,455	377,040	510,495	2,244	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36,071	101,909	137,980	748	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,329	68,736	93,065	609	68.00
69.00	06900	ELECTROCARDIOLOGY	0	142,966	403,910	546,876	3,521	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,772	5,005	6,777	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	50,344	142,232	192,576	360	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	30,850	87,157	118,007	2	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	90,957	256,974	347,931	2,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,498,074	12,708,043	17,206,117	49,985	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,955	13,999	18,954	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	191	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	114	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,503,029	12,722,042	17,225,071	50,290	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	687,458					5.00
7.00	00700	OPERATION OF PLANT	131,320	10,901,048				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,338	33,463	54,379			8.00
9.00	00900	HOUSEKEEPING	12,503	119,062	0	194,110		9.00
10.00	01000	DIETARY	7,818	187,055	0	3,378	296,513	10.00
11.00	01100	CAFETERIA	9,728	118,334	0	2,137	0	11.00
13.00	01300	NURSING ADMINISTRATION	22,151	88,217	0	1,593	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,692	241,809	0	4,367	0	14.00
15.00	01500	PHARMACY	12,334	158,975	0	2,871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,887	40,011	0	723	0	16.00
17.00	01700	SOCIAL SERVICE	5,418	29,438	0	532	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,402	1,803,386	23,851	32,569	195,853	30.00
31.00	03100	INTENSIVE CARE UNIT	30,178	557,043	4,387	10,060	21,826	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	3,714	5,286	0	95	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,198	1,142,118	7,161	20,626	0	50.00
51.00	05100	RECOVERY ROOM	13,359	111,544	1,917	2,014	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,618	737,358	0	13,316	0	52.00
53.00	05300	ANESTHESIOLOGY	1,443	17,847	0	322	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,475	1,093,572	4,571	19,749	0	54.00
54.01	05401	ULTRASOUND	3,249	33,560	0	606	0	54.01
56.00	05600	RADIOISOTOPE	4,098	54,996	0	993	0	56.00
57.00	05700	CT SCAN	5,326	55,336	0	999	0	57.00
58.00	05800	MRI	1,863	65,326	0	1,180	0	58.00
60.00	06000	LABORATORY	33,035	376,972	0	6,808	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,715	19,399	0	350	0	62.00
65.00	06500	RESPIRATORY THERAPY	9,209	55,724	0	1,006	0	65.00
66.00	06600	PHYSICAL THERAPY	19,348	971,795	0	17,550	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,064	262,663	0	4,743	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,187	177,162	0	3,199	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,402	1,041,049	1,943	18,801	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,923	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,485	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,804	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,093	12,900	0	233	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,861	366,593	103	6,620	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	5,967	224,641	0	4,057	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	25,034	662,332	10,446	11,961	15,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	684,239	10,864,966	54,379	193,458	233,586	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	124	36,082	0	652	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,930	0	0	0	62,868	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	1,165	0	0	0	59	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	687,458	10,901,048	54,379	194,110	296,513	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	192,362					11.00
13.00	01300	NURSING ADMINISTRATION	11,289	172,754				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,911	0	387,473			14.00
15.00	01500	PHARMACY	6,791	0	1,470	267,615		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,747	0	226	0	74,134	16.00
17.00	01700	SOCIAL SERVICE	2,669	4	52	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,789	59,379	18,399	0	5,891	30.00
31.00	03100	INTENSIVE CARE UNIT	11,553	28,676	12,932	0	1,508	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,808	0	0	0	240	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,578	11,810	44,021	0	10,996	50.00
51.00	05100	RECOVERY ROOM	7,324	13,674	5,784	0	1,835	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,820	19,260	6,155	0	492	52.00
53.00	05300	ANESTHESIOLOGY	465	0	4,773	0	2,717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,174	4,836	3,214	0	1,452	54.00
54.01	05401	ULTRASOUND	1,535	0	596	0	800	54.01
56.00	05600	RADIOISOTOPE	1,300	5	5,871	0	1,133	56.00
57.00	05700	CT SCAN	3,445	417	1,987	0	3,427	57.00
58.00	05800	MRI	972	52	447	0	1,171	58.00
60.00	06000	LABORATORY	18,075	0	43,095	0	8,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	772	0	16,852	0	258	62.00
65.00	06500	RESPIRATORY THERAPY	6,152	0	1,258	0	1,133	65.00
66.00	06600	PHYSICAL THERAPY	10,048	0	407	0	1,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,150	0	85	0	736	67.00
68.00	06800	SPEECH PATHOLOGY	2,519	0	108	0	495	68.00
69.00	06900	ELECTROCARDIOLOGY	14,533	12,981	14,447	0	5,941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	18,646	0	1,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	169,988	0	3,352	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	267,615	13,876	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	469	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,867	0	580	0	424	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	21	0	3,323	0	281	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,571	20,513	12,501	0	4,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,878	171,607	387,217	267,615	74,134	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	857	1,147	243	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	627	0	13	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	192,362	172,754	387,473	267,615	74,134	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B Part II | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	54,202					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,154	3,259,065	0	3,259,065		30.00
31.00	03100	INTENSIVE CARE UNIT	7,969	981,758	0	981,758		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	3,079	17,496	0	17,496		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,885,142	0	1,885,142		50.00
51.00	05100	RECOVERY ROOM	0	217,822	0	217,822		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,176,082	0	1,176,082		52.00
53.00	05300	ANESTHESIOLOGY	0	37,001	0	37,001		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,731,601	0	1,731,601		54.00
54.01	05401	ULTRASOUND	0	58,423	0	58,423		54.01
56.00	05600	RADIOISOTOPE	0	97,665	0	97,665		56.00
57.00	05700	CT SCAN	0	100,695	0	100,695		57.00
58.00	05800	MRI	0	105,551	0	105,551		58.00
60.00	06000	LABORATORY	0	686,913	0	686,913		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	52,713	0	52,713		62.00
65.00	06500	RESPIRATORY THERAPY	0	105,010	0	105,010		65.00
66.00	06600	PHYSICAL THERAPY	0	1,533,424	0	1,533,424		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	416,169	0	416,169		67.00
68.00	06800	SPEECH PATHOLOGY	0	282,344	0	282,344		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,692,494	0	1,692,494		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,230	0	25,230		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	206,825	0	206,825		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	355,295	0	355,295		73.00
74.00	07400	RENAL DIALYSIS	0	23,472	0	23,472		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	572,984	0	572,984		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	356,299	0	356,299		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,122,572	0	1,122,572		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,202	17,100,045	0	17,100,045		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	55,812	0	55,812		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	67,236	0	67,236		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	1,978	0	1,978		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	54,202	17,225,071	0	17,225,071		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	676,120					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		676,120				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,974	1,974	41,120,657			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,688	26,688	6,169,514	-32,183,910	104,721,757	5.00
7.00	00700	OPERATION OF PLANT	422,683	422,683	1,069,285	0	20,008,917	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	690	0	0	508,480	8.00
9.00	00900	HOUSEKEEPING	2,455	2,455	0	0	1,904,455	9.00
10.00	01000	DIETARY	3,857	3,857	0	0	1,190,877	10.00
11.00	01100	CAFETERIA	2,440	2,440	0	0	1,481,866	11.00
13.00	01300	NURSING ADMINISTRATION	1,819	1,819	2,585,346	0	3,374,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,986	4,986	547,367	0	1,323,921	14.00
15.00	01500	PHARMACY	3,278	3,278	1,359,161	0	1,878,808	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825	825	426,818	0	1,201,416	16.00
17.00	01700	SOCIAL SERVICE	607	607	511,298	0	825,223	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,185	37,185	6,585,236	0	12,399,322	30.00
31.00	03100	INTENSIVE CARE UNIT	11,486	11,486	2,457,054	0	4,596,815	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	109	109	406,346	0	565,669	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,550	23,550	2,179,637	0	4,904,540	50.00
51.00	05100	RECOVERY ROOM	2,300	2,300	1,451,801	0	2,034,877	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,204	15,204	589,771	0	1,160,471	52.00
53.00	05300	ANESTHESIOLOGY	368	368	48,561	0	219,852	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,549	22,549	1,709,465	0	2,814,175	54.00
54.01	05401	ULTRASOUND	692	692	365,773	0	494,857	54.01
56.00	05600	RADIOISOTOPE	1,134	1,134	309,333	0	624,231	56.00
57.00	05700	CT SCAN	1,141	1,141	564,221	0	811,341	57.00
58.00	05800	MRI	1,347	1,347	183,051	0	283,775	58.00
60.00	06000	LABORATORY	7,773	7,773	2,138,643	0	5,031,929	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	400	400	145,048	0	718,173	62.00
65.00	06500	RESPIRATORY THERAPY	1,149	1,149	1,027,156	0	1,402,779	65.00
66.00	06600	PHYSICAL THERAPY	20,038	20,038	1,834,872	0	2,947,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,416	5,416	611,207	0	923,614	67.00
68.00	06800	SPEECH PATHOLOGY	3,653	3,653	498,224	0	790,152	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	21,466	2,879,169	0	4,935,615	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	749,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,100,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,242,052	73.00
74.00	07400	RENAL DIALYSIS	266	266	0	0	471,065	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,559	7,559	294,198	0	588,050	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,632	4,632	1,691	0	908,970	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,657	13,657	1,922,208	0	3,813,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	675,376	675,376	40,871,454	-32,183,910	104,231,255	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	18,954	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	156,368	0	294,055	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	92,835	0	177,493	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	4,503,029	12,722,042	7,068,474		32,183,910	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.660103	18.816249	0.171896		0.307328	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			50,290		687,458	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001223		0.006565	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
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: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	224,775					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	442,627				8.00
9.00	00900	HOUSEKEEPING	2,455	0	221,630			9.00
10.00	01000	DIETARY	3,857	0	3,857	80,099		10.00
11.00	01100	CAFETERIA	2,440	0	2,440	0	45,123	11.00
13.00	01300	NURSING ADMINISTRATION	1,819	0	1,819	0	2,648	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,986	0	4,986	0	1,152	14.00
15.00	01500	PHARMACY	3,278	0	3,278	0	1,593	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825	0	825	0	879	16.00
17.00	01700	SOCIAL SERVICE	607	0	607	0	626	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,185	194,136	37,185	52,907	9,334	30.00
31.00	03100	INTENSIVE CARE UNIT	11,486	35,711	11,486	5,896	2,710	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	109	0	109	0	424	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,550	58,286	23,550	0	3,185	50.00
51.00	05100	RECOVERY ROOM	2,300	15,603	2,300	0	1,718	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,204	0	15,204	0	896	52.00
53.00	05300	ANESTHESIOLOGY	368	0	368	0	109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,549	37,206	22,549	0	2,152	54.00
54.01	05401	ULTRASOUND	692	0	692	0	360	54.01
56.00	05600	RADIOISOTOPE	1,134	0	1,134	0	305	56.00
57.00	05700	CT SCAN	1,141	0	1,141	0	808	57.00
58.00	05800	MRI	1,347	0	1,347	0	228	58.00
60.00	06000	LABORATORY	7,773	0	7,773	0	4,240	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	400	0	400	0	181	62.00
65.00	06500	RESPIRATORY THERAPY	1,149	0	1,149	0	1,443	65.00
66.00	06600	PHYSICAL THERAPY	20,038	0	20,038	0	2,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,416	0	5,416	0	739	67.00
68.00	06800	SPEECH PATHOLOGY	3,653	0	3,653	0	591	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	15,818	21,466	0	3,409	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	266	0	266	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,559	836	7,559	0	438	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,632	0	4,632	0	5	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,657	85,031	13,657	4,297	2,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,031	442,627	220,886	63,100	44,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	0	744	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,983	201	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	16	147	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	26,158,201	745,049	2,775,448	2,054,027	2,251,796	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	116.375046	1.683243	12.522890	25.643604	49.903508	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,901,048	54,379	194,110	296,513	192,362	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	48.497600	0.122855	0.875829	3.701831	4.263059	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,865,085					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,082,107				14.00
15.00	01500	PHARMACY	0	45,826	11,252,094			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,037	0	735,939,687		16.00
17.00	01700	SOCIAL SERVICE	339	1,622	0	0	23,344	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,765,874	573,708	0	58,321,830	18,586	30.00
31.00	03100	INTENSIVE CARE UNIT	2,301,448	403,251	0	14,929,321	3,432	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	2,378,432	1,326	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	947,817	1,372,648	0	108,871,295	0	50.00
51.00	05100	RECOVERY ROOM	1,097,441	180,355	0	18,166,755	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,545,786	191,928	0	4,870,519	0	52.00
53.00	05300	ANESTHESIOLOGY	0	148,820	0	26,902,433	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,141	100,220	0	14,379,603	0	54.00
54.01	05401	ULTRASOUND	0	18,583	0	7,918,167	0	54.01
56.00	05600	RADIOISOTOPE	369	183,066	0	11,217,558	0	56.00
57.00	05700	CT SCAN	33,442	61,969	0	33,931,594	0	57.00
58.00	05800	MRI	4,184	13,929	0	11,598,265	0	58.00
60.00	06000	LABORATORY	0	1,343,769	0	82,015,269	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	525,470	0	2,551,281	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,238	0	11,221,226	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,683	0	15,217,976	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,638	0	7,292,003	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,368	0	4,900,678	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,041,835	450,497	0	58,820,932	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	581,411	0	16,446,549	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,300,567	0	33,183,835	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,252,094	139,316,040	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,647,954	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	18,082	0	4,200,755	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	103,625	0	2,786,702	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,646,346	389,801	0	39,852,715	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,773,022	12,074,111	11,252,094	735,939,687	23,344	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,063	7,591	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	405	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	4,777,745	2,430,973	2,967,461	1,722,266	1,188,761	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.344588	0.201204	0.263725	0.002340	50.923621	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	172,754	387,473	267,615	74,134	54,202	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.012460	0.032070	0.023784	0.000101	2.321881	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet B-1 | Date/Time Prepared: 5/30/2022 4:01 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		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	25,992,988		25,992,988	0	25,992,988	30.00
31.00	03100	INTENSIVE CARE UNIT	8,920,503		8,920,503	0	8,920,503	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	847,815		847,815	0	847,815	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,561,988		10,561,988	0	10,561,988	50.00
51.00	05100	RECOVERY ROOM	3,525,679		3,525,679	0	3,525,679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,104,267		4,104,267	0	4,104,267	52.00
53.00	05300	ANESTHESIOLOGY	433,187		433,187	0	433,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,943,151		6,943,151	0	6,943,151	54.00
54.01	05401	ULTRASOUND	776,371		776,371	0	776,371	54.01
56.00	05600	RADIOISOTOPE	1,040,676		1,040,676	0	1,040,676	56.00
57.00	05700	CT SCAN	1,351,476		1,351,476	0	1,351,476	57.00
58.00	05800	MRI	587,375		587,375	0	587,375	58.00
60.00	06000	LABORATORY	8,254,184		8,254,184	0	8,254,184	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,111,177		1,111,177	0	1,111,177	62.00
65.00	06500	RESPIRATORY THERAPY	2,088,160	0	2,088,160	0	2,088,160	65.00
66.00	06600	PHYSICAL THERAPY	6,591,570	0	6,591,570	0	6,591,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,960,050	0	1,960,050	0	1,960,050	67.00
68.00	06800	SPEECH PATHOLOGY	1,545,491	0	1,545,491	0	1,545,491	68.00
69.00	06900	ELECTROCARDIOLOGY	10,003,425		10,003,425	0	10,003,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,135,772		1,135,772	0	1,135,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,812,247		7,812,247	0	7,812,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,990,675		17,990,675	0	17,990,675	73.00
74.00	07400	RENAL DIALYSIS	660,999		660,999	0	660,999	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	1,779,847		1,779,847	0	1,779,847	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,812,998		1,812,998	0	1,812,998	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	7,849,835		7,849,835	0	7,849,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,766,229		1,766,229		1,766,229	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	137,448,135	0	137,448,135	0	137,448,135	200.00
201.00		Less Observation Beds	1,766,229		1,766,229		1,766,229	201.00
202.00		Total (see instructions)	135,681,906	0	135,681,906	0	135,681,906	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		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	55,069,657		55,069,657			30.00
31.00	03100	INTENSIVE CARE UNIT	14,929,321		14,929,321			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,378,432		2,378,432			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,585,063	81,286,232	108,871,295	0.097014	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,104,685	14,062,070	18,166,755	0.194073	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,550,591	1,319,928	4,870,519	0.842675	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,887,164	19,015,269	26,902,433	0.016102	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,881,780	11,497,823	14,379,603	0.482847	0.000000	54.00
54.01	05401	ULTRASOUND	1,347,936	6,570,231	7,918,167	0.098049	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,217,653	9,999,905	11,217,558	0.092772	0.000000	56.00
57.00	05700	CT SCAN	10,353,215	23,578,379	33,931,594	0.039829	0.000000	57.00
58.00	05800	MRI	2,568,554	9,029,711	11,598,265	0.050643	0.000000	58.00
60.00	06000	LABORATORY	33,246,065	48,769,204	82,015,269	0.100642	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,100,425	450,856	2,551,281	0.435537	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	10,202,574	1,018,652	11,221,226	0.186090	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,087,706	11,130,270	15,217,976	0.433144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,224,553	3,067,450	7,292,003	0.268794	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,707,523	3,193,155	4,900,678	0.315363	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	21,392,089	37,428,843	58,820,932	0.170066	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,887,728	8,558,821	16,446,549	0.069058	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,083,478	20,100,357	33,183,835	0.235423	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,430,015	79,886,025	139,316,040	0.129136	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,647,954	0	4,647,954	0.142213	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	330,318	3,870,437	4,200,755	0.423697	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	29,165	2,757,537	2,786,702	0.650589	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	12,090,019	27,762,696	39,852,715	0.196971	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,096,490	2,155,683	3,252,173	0.543092	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	309,430,153	426,509,534	735,939,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	309,430,153	426,509,534	735,939,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.097014	50.00
51.00	05100	RECOVERY ROOM	0.194073	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	54.00
54.01	05401	ULTRASOUND	0.098049	54.01
56.00	05600	RADIOISOTOPE	0.092772	56.00
57.00	05700	CT SCAN	0.039829	57.00
58.00	05800	MRI	0.050643	58.00
60.00	06000	LABORATORY	0.100642	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	73.00
74.00	07400	RENAL DIALYSIS	0.142213	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	76.00
76.01	03610	SLEEP LAB	0.423697	76.01
76.02	03020	ACUPUNCTURE	0.000000	76.02
76.03	03040	WOUND CARE	0.650589	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.196971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		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	25,992,988		25,992,988	0	25,992,988	30.00
31.00	03100	INTENSIVE CARE UNIT	8,920,503		8,920,503	0	8,920,503	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	847,815		847,815	0	847,815	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,561,988		10,561,988	0	10,561,988	50.00
51.00	05100	RECOVERY ROOM	3,525,679		3,525,679	0	3,525,679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,104,267		4,104,267	0	4,104,267	52.00
53.00	05300	ANESTHESIOLOGY	433,187		433,187	0	433,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,943,151		6,943,151	0	6,943,151	54.00
54.01	05401	ULTRASOUND	776,371		776,371	0	776,371	54.01
56.00	05600	RADIOISOTOPE	1,040,676		1,040,676	0	1,040,676	56.00
57.00	05700	CT SCAN	1,351,476		1,351,476	0	1,351,476	57.00
58.00	05800	MRI	587,375		587,375	0	587,375	58.00
60.00	06000	LABORATORY	8,254,184		8,254,184	0	8,254,184	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,111,177		1,111,177	0	1,111,177	62.00
65.00	06500	RESPIRATORY THERAPY	2,088,160	0	2,088,160	0	2,088,160	65.00
66.00	06600	PHYSICAL THERAPY	6,591,570	0	6,591,570	0	6,591,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,960,050	0	1,960,050	0	1,960,050	67.00
68.00	06800	SPEECH PATHOLOGY	1,545,491	0	1,545,491	0	1,545,491	68.00
69.00	06900	ELECTROCARDIOLOGY	10,003,425		10,003,425	0	10,003,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,135,772		1,135,772	0	1,135,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,812,247		7,812,247	0	7,812,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,990,675		17,990,675	0	17,990,675	73.00
74.00	07400	RENAL DIALYSIS	660,999		660,999	0	660,999	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	1,779,847		1,779,847	0	1,779,847	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,812,998		1,812,998	0	1,812,998	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	7,849,835		7,849,835	0	7,849,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,766,229		1,766,229		1,766,229	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	137,448,135	0	137,448,135	0	137,448,135	200.00
201.00		Less Observation Beds	1,766,229		1,766,229		1,766,229	201.00
202.00		Total (see instructions)	135,681,906	0	135,681,906	0	135,681,906	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		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	55,069,657		55,069,657			30.00
31.00	03100	INTENSIVE CARE UNIT	14,929,321		14,929,321			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,378,432		2,378,432			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,585,063	81,286,232	108,871,295	0.097014	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,104,685	14,062,070	18,166,755	0.194073	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,550,591	1,319,928	4,870,519	0.842675	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,887,164	19,015,269	26,902,433	0.016102	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,881,780	11,497,823	14,379,603	0.482847	0.000000	54.00
54.01	05401	ULTRASOUND	1,347,936	6,570,231	7,918,167	0.098049	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,217,653	9,999,905	11,217,558	0.092772	0.000000	56.00
57.00	05700	CT SCAN	10,353,215	23,578,379	33,931,594	0.039829	0.000000	57.00
58.00	05800	MRI	2,568,554	9,029,711	11,598,265	0.050643	0.000000	58.00
60.00	06000	LABORATORY	33,246,065	48,769,204	82,015,269	0.100642	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,100,425	450,856	2,551,281	0.435537	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	10,202,574	1,018,652	11,221,226	0.186090	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,087,706	11,130,270	15,217,976	0.433144	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,224,553	3,067,450	7,292,003	0.268794	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,707,523	3,193,155	4,900,678	0.315363	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	21,392,089	37,428,843	58,820,932	0.170066	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,887,728	8,558,821	16,446,549	0.069058	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,083,478	20,100,357	33,183,835	0.235423	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,430,015	79,886,025	139,316,040	0.129136	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,647,954	0	4,647,954	0.142213	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	330,318	3,870,437	4,200,755	0.423697	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	29,165	2,757,537	2,786,702	0.650589	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	12,090,019	27,762,696	39,852,715	0.196971	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,096,490	2,155,683	3,252,173	0.543092	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	309,430,153	426,509,534	735,939,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	309,430,153	426,509,534	735,939,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/30/2022 4:01 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.097014	50.00
51.00	05100	RECOVERY ROOM	0.194073	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	54.00
54.01	05401	ULTRASOUND	0.098049	54.01
56.00	05600	RADIOISOTOPE	0.092772	56.00
57.00	05700	CT SCAN	0.039829	57.00
58.00	05800	MRI	0.050643	58.00
60.00	06000	LABORATORY	0.100642	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	73.00
74.00	07400	RENAL DIALYSIS	0.142213	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	76.00
76.01	03610	SLEEP LAB	0.423697	76.01
76.02	03020	ACUPUNCTURE	0.000000	76.02
76.03	03040	WOUND CARE	0.650589	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.196971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,561,988	1,885,142	8,676,846	0	0	50.00
51.00	05100	RECOVERY ROOM	3,525,679	217,822	3,307,857	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,104,267	1,176,082	2,928,185	0	0	52.00
53.00	05300	ANESTHESIOLOGY	433,187	37,001	396,186	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,943,151	1,731,601	5,211,550	0	0	54.00
54.01	05401	ULTRASOUND	776,371	58,423	717,948	0	0	54.01
56.00	05600	RADIOISOTOPE	1,040,676	97,665	943,011	0	0	56.00
57.00	05700	CT SCAN	1,351,476	100,695	1,250,781	0	0	57.00
58.00	05800	MRI	587,375	105,551	481,824	0	0	58.00
60.00	06000	LABORATORY	8,254,184	686,913	7,567,271	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,111,177	52,713	1,058,464	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,088,160	105,010	1,983,150	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,591,570	1,533,424	5,058,146	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,960,050	416,169	1,543,881	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,545,491	282,344	1,263,147	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,003,425	1,692,494	8,310,931	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,135,772	25,230	1,110,542	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,812,247	206,825	7,605,422	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,990,675	355,295	17,635,380	0	0	73.00
74.00	07400	RENAL DIALYSIS	660,999	23,472	637,527	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,779,847	572,984	1,206,863	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,812,998	356,299	1,456,699	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,849,835	1,122,572	6,727,263	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,766,229	221,453	1,544,776	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	101,686,829	13,063,179	88,623,650	0	0	200.00
201.00		Less Observation Beds	1,766,229	221,453	1,544,776	0	0	201.00
202.00		Total (line 200 minus line 201)	99,920,600	12,841,726	87,078,874	0	0	202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part II Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,561,988	108,871,295	0.097014		50.00
51.00	05100	RECOVERY ROOM	3,525,679	18,166,755	0.194073		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,104,267	4,870,519	0.842675		52.00
53.00	05300	ANESTHESIOLOGY	433,187	26,902,433	0.016102		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,943,151	14,379,603	0.482847		54.00
54.01	05401	ULTRASOUND	776,371	7,918,167	0.098049		54.01
56.00	05600	RADIOISOTOPE	1,040,676	11,217,558	0.092772		56.00
57.00	05700	CT SCAN	1,351,476	33,931,594	0.039829		57.00
58.00	05800	MRI	587,375	11,598,265	0.050643		58.00
60.00	06000	LABORATORY	8,254,184	82,015,269	0.100642		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,111,177	2,551,281	0.435537		62.00
65.00	06500	RESPIRATORY THERAPY	2,088,160	11,221,226	0.186090		65.00
66.00	06600	PHYSICAL THERAPY	6,591,570	15,217,976	0.433144		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,960,050	7,292,003	0.268794		67.00
68.00	06800	SPEECH PATHOLOGY	1,545,491	4,900,678	0.315363		68.00
69.00	06900	ELECTROCARDIOLOGY	10,003,425	58,820,932	0.170066		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,135,772	16,446,549	0.069058		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,812,247	33,183,835	0.235423		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,990,675	139,316,040	0.129136		73.00
74.00	07400	RENAL DIALYSIS	660,999	4,647,954	0.142213		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	1,779,847	4,200,755	0.423697		76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000		76.02
76.03	03040	WOUND CARE	1,812,998	2,786,702	0.650589		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	7,849,835	39,852,715	0.196971		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,766,229	3,252,173	0.543092		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	101,686,829	663,562,277			200.00
201.00		Less Observation Beds	1,766,229	0			201.00
202.00		Total (line 200 minus line 201)	99,920,600	663,562,277			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,259,065	0	3,259,065	19,941	163.44	30.00
31.00	INTENSIVE CARE UNIT	981,758		981,758	3,432	286.06	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	17,496		17,496	1,326	13.19	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	4,258,319		4,258,319	24,699		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	7,211	1,178,566	30.00
31.00	INTENSIVE CARE UNIT	1,169	334,404	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	8,380	1,512,970	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,885,142	108,871,295	0.017315	8,990,580	155,672	50.00
51.00	05100	RECOVERY ROOM	217,822	18,166,755	0.011990	1,316,883	15,789	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,082	4,870,519	0.241470	29,315	7,079	52.00
53.00	05300	ANESTHESIOLOGY	37,001	26,902,433	0.001375	2,467,604	3,393	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,731,601	14,379,603	0.120421	1,281,463	154,315	54.00
54.01	05401	ULTRASOUND	58,423	7,918,167	0.007378	481,621	3,553	54.01
56.00	05600	RADIOISOTOPE	97,665	11,217,558	0.008706	464,460	4,044	56.00
57.00	05700	CT SCAN	100,695	33,931,594	0.002968	3,866,789	11,477	57.00
58.00	05800	MRI	105,551	11,598,265	0.009101	966,445	8,796	58.00
60.00	06000	LABORATORY	686,913	82,015,269	0.008375	11,937,633	99,978	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,713	2,551,281	0.020661	1,018,342	21,040	62.00
65.00	06500	RESPIRATORY THERAPY	105,010	11,221,226	0.009358	3,549,731	33,218	65.00
66.00	06600	PHYSICAL THERAPY	1,533,424	15,217,976	0.100764	1,806,717	182,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	416,169	7,292,003	0.057072	1,861,661	106,249	67.00
68.00	06800	SPEECH PATHOLOGY	282,344	4,900,678	0.057613	811,089	46,729	68.00
69.00	06900	ELECTROCARDIOLOGY	1,692,494	58,820,932	0.028774	7,734,052	222,540	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,230	16,446,549	0.001534	2,508,689	3,848	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,825	33,183,835	0.006233	5,093,158	31,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	355,295	139,316,040	0.002550	22,034,939	56,189	73.00
74.00	07400	RENAL DIALYSIS	23,472	4,647,954	0.005050	2,435,857	12,301	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	572,984	4,200,755	0.136400	110,495	15,072	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	356,299	2,786,702	0.127857	27,379	3,501	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,122,572	39,852,715	0.028168	4,347,072	122,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,453	3,252,173	0.068094	444,674	30,280	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	13,063,179	663,562,277		85,586,648	1,351,309	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	19,941	0.00	7,211	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,432	0.00	1,169	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,326	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	24,699		8,380	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV | Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,871,295	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	18,166,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,870,519	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,902,433	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,379,603	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	7,918,167	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	11,217,558	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,931,594	0.000000	57.00
58.00	05800	MRI	0	0	0	11,598,265	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	82,015,269	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,551,281	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,221,226	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,217,976	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,292,003	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,900,678	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	58,820,932	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,446,549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,183,835	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	139,316,040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,647,954	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	4,200,755	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	2,786,702	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,852,715	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,252,173	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	663,562,277		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/30/2022 4:01 pm

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		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	8,990,580	0	20,821,229	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,316,883	0	3,016,969	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	29,315	0	228,880	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,467,604	0	4,325,534	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,281,463	0	2,674,519	0	54.00
54.01	05401	ULTRASOUND	0.000000	481,621	0	942,940	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	464,460	0	3,726,214	0	56.00
57.00	05700	CT SCAN	0.000000	3,866,789	0	6,017,123	0	57.00
58.00	05800	MRI	0.000000	966,445	0	2,385,330	0	58.00
60.00	06000	LABORATORY	0.000000	11,937,633	0	4,435,783	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	1,018,342	0	228,380	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,549,731	0	294,015	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,806,717	0	22,343	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,861,661	0	16,707	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	811,089	0	18,536	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,734,052	0	12,979,053	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,508,689	0	1,652,391	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,093,158	0	6,667,567	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,034,939	0	28,978,174	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,435,857	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	110,495	0	760,364	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	27,379	0	1,245,690	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,347,072	0	4,081,791	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	444,674	0	559,819	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		85,586,648	0	106,079,351	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.097014	20,821,229	0	0	2,019,951	50.00
51.00	05100	RECOVERY ROOM	0.194073	3,016,969	0	0	585,512	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	228,880	0	0	192,871	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	4,325,534	0	0	69,650	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	2,674,519	0	0	1,291,383	54.00
54.01	05401	ULTRASOUND	0.098049	942,940	0	0	92,454	54.01
56.00	05600	RADIOISOTOPE	0.092772	3,726,214	0	0	345,688	56.00
57.00	05700	CT SCAN	0.039829	6,017,123	0	0	239,656	57.00
58.00	05800	MRI	0.050643	2,385,330	0	0	120,800	58.00
60.00	06000	LABORATORY	0.100642	4,435,783	0	0	446,426	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	228,380	0	0	99,468	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	294,015	0	0	54,713	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	22,343	5,453	0	9,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	16,707	0	0	4,491	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	18,536	0	0	5,846	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	12,979,053	0	0	2,207,296	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	1,652,391	0	0	114,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	6,667,567	0	0	1,569,699	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	28,978,174	0	14,614	3,742,125	73.00
74.00	07400	RENAL DIALYSIS	0.142213	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.423697	760,364	0	0	322,164	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.650589	1,245,690	0	0	810,432	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.196971	4,081,791	0	0	803,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	559,819	0	0	304,033	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		106,079,351	5,453	14,614	15,452,441	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		106,079,351	5,453	14,614	15,452,441	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	2,362	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 PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,887		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,362	1,887		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,362	1,887		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,259,065	0	3,259,065	19,941	163.44	30.00
31.00	INTENSIVE CARE UNIT	981,758		981,758	3,432	286.06	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	17,496		17,496	1,326	13.19	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	4,258,319		4,258,319	24,699		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	610	99,698	30.00
31.00	INTENSIVE CARE UNIT	33	9,440	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	1,011	13,335	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,654	122,473	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part II Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,885,142	108,871,295	0.017315	888,867	15,391	50.00
51.00	05100	RECOVERY ROOM	217,822	18,166,755	0.011990	169,302	2,030	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,176,082	4,870,519	0.241470	109,523	26,447	52.00
53.00	05300	ANESTHESIOLOGY	37,001	26,902,433	0.001375	242,975	334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,731,601	14,379,603	0.120421	68,420	8,239	54.00
54.01	05401	ULTRASOUND	58,423	7,918,167	0.007378	49,435	365	54.01
56.00	05600	RADIOISOTOPE	97,665	11,217,558	0.008706	25,923	226	56.00
57.00	05700	CT SCAN	100,695	33,931,594	0.002968	275,494	818	57.00
58.00	05800	MRI	105,551	11,598,265	0.009101	90,524	824	58.00
60.00	06000	LABORATORY	686,913	82,015,269	0.008375	1,110,707	9,302	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,713	2,551,281	0.020661	36,635	757	62.00
65.00	06500	RESPIRATORY THERAPY	105,010	11,221,226	0.009358	275,927	2,582	65.00
66.00	06600	PHYSICAL THERAPY	1,533,424	15,217,976	0.100764	109,701	11,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	416,169	7,292,003	0.057072	101,359	5,785	67.00
68.00	06800	SPEECH PATHOLOGY	282,344	4,900,678	0.057613	74,583	4,297	68.00
69.00	06900	ELECTROCARDIOLOGY	1,692,494	58,820,932	0.028774	312,490	8,992	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,230	16,446,549	0.001534	288,262	442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,825	33,183,835	0.006233	157,853	984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	355,295	139,316,040	0.002550	1,533,292	3,910	73.00
74.00	07400	RENAL DIALYSIS	23,472	4,647,954	0.005050	61,053	308	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	572,984	4,200,755	0.136400	8,598	1,173	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	356,299	2,786,702	0.127857	1,786	228	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,122,572	39,852,715	0.028168	343,102	9,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,453	3,252,173	0.068094	33,570	2,286	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	13,063,179	663,562,277		6,369,381	116,438	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part III Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	19,941	0.00	610	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,432	0.00	33	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,326	0.00	1,011	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	24,699		1,654	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	108,871,295	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	18,166,755	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,870,519	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,902,433	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,379,603	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	7,918,167	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	11,217,558	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	33,931,594	0.000000	57.00
58.00	05800	MRI	0	0	0	11,598,265	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	82,015,269	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,551,281	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,221,226	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,217,976	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,292,003	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,900,678	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	58,820,932	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,446,549	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,183,835	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	139,316,040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,647,954	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	4,200,755	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	2,786,702	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	39,852,715	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,252,173	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	663,562,277		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part IV Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	888,867	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	169,302	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	109,523	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	242,975	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	68,420	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	49,435	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	25,923	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	275,494	0	0	0	57.00
58.00	05800	MRI	0.000000	90,524	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,110,707	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	36,635	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	275,927	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	109,701	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	101,359	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	74,583	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	312,490	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	288,262	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	157,853	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,533,292	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	61,053	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	8,598	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	1,786	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	343,102	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	33,570	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		6,369,381	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.097014	0	0	1,388,514	0	50.00
51.00	05100	RECOVERY ROOM	0.194073	0	0	263,547	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	0	0	321,505	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	0	0	180,652	0	54.00
54.01	05401	ULTRASOUND	0.098049	0	0	160,607	0	54.01
56.00	05600	RADIOISOTOPE	0.092772	0	0	54,184	0	56.00
57.00	05700	CT SCAN	0.039829	0	0	704,700	0	57.00
58.00	05800	MRI	0.050643	0	0	145,964	0	58.00
60.00	06000	LABORATORY	0.100642	0	0	1,069,998	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	0	0	890	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	0	0	14,076	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	0	0	23,767	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	0	0	18,778	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	0	0	13,483	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	0	0	290,153	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	0	0	217,139	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	0	0	413,669	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	0	0	572,167	0	73.00
74.00	07400	RENAL DIALYSIS	0.142213	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.423697	0	0	16,162	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.650589	0	0	115,592	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.196971	0	0	1,240,156	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	0	0	115,603	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	7,341,306	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	7,341,306	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D Part V Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		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	0	134,705		50.00
51.00	05100	RECOVERY ROOM	0	51,147		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	5,177		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87,227		54.00
54.01	05401	ULTRASOUND	0	15,747		54.01
56.00	05600	RADIOISOTOPE	0	5,027		56.00
57.00	05700	CT SCAN	0	28,067		57.00
58.00	05800	MRI	0	7,392		58.00
60.00	06000	LABORATORY	0	107,687		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	388		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,619		65.00
66.00	06600	PHYSICAL THERAPY	0	10,295		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,047		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,252		68.00
69.00	06900	ELECTROCARDIOLOGY	0	49,345		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,995		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	97,387		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73,887		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	6,848		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	75,203		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	244,275		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	62,783		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,089,500		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,089,500		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,941	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,941	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)	18,586	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7,211	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	25,992,988	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	25,992,988	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)	25,992,988	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,303.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,399,466	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)	9,399,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/30/2022 4:01 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,920,503	3,432	2,599.21	1,169	3,038,476	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)	12,990,396	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	25,428,338	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)	1,512,970	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,351,309	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,864,279	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,564,059	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,355	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,303.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,766,229	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,259,065	25,992,988	0.125382	1,766,229	221,453	90.00
91.00	Nursing Program cost	0	25,992,988	0.000000	1,766,229	0	91.00
92.00	Allied health cost	0	25,992,988	0.000000	1,766,229	0	92.00
93.00	All other Medical Education	0	25,992,988	0.000000	1,766,229	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,941	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,941	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)	18,586	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	610	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)	1,326	15.00
16.00	Nursery days (title V or XIX only)	1,011	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	25,992,988	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	25,992,988	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)	25,992,988	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,303.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	795,129	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)	795,129	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	847,815	1,326	639.38	1,011	646,413	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,920,503	3,432	2,599.21	33	85,774	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)	956,025	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,483,341	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)	122,473	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	116,438	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	238,911	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,244,430	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,355	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,303.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,766,229	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-1 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,259,065	25,992,988	0.125382	1,766,229	221,453	90.00
91.00	Nursing Program cost	0	25,992,988	0.000000	1,766,229	0	91.00
92.00	Allied health cost	0	25,992,988	0.000000	1,766,229	0	92.00
93.00	All other Medical Education	0	25,992,988	0.000000	1,766,229	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		20,617,223		30.00
31.00	03100	INTENSIVE CARE UNIT		5,055,115		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.097014	8,990,580	872,212	50.00
51.00	05100	RECOVERY ROOM	0.194073	1,316,883	255,571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	29,315	24,703	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	2,467,604	39,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	1,281,463	618,751	54.00
54.01	05401	ULTRASOUND	0.098049	481,621	47,222	54.01
56.00	05600	RADIOISOTOPE	0.092772	464,460	43,089	56.00
57.00	05700	CT SCAN	0.039829	3,866,789	154,010	57.00
58.00	05800	MRI	0.050643	966,445	48,944	58.00
60.00	06000	LABORATORY	0.100642	11,937,633	1,201,427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	1,018,342	443,526	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	3,549,731	660,569	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	1,806,717	782,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	1,861,661	500,403	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	811,089	255,787	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	7,734,052	1,315,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	2,508,689	173,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	5,093,158	1,199,047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	22,034,939	2,845,504	73.00
74.00	07400	RENAL DIALYSIS	0.142213	2,435,857	346,411	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.423697	110,495	46,816	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.650589	27,379	17,812	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.196971	4,347,072	856,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	444,674	241,499	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		85,586,648	12,990,396	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)		85,586,648		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,670,682		30.00
31.00	03100	INTENSIVE CARE UNIT		468,773		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		163,878		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.097014	888,867	86,233	50.00
51.00	05100	RECOVERY ROOM	0.194073	169,302	32,857	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	109,523	92,292	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	242,975	3,912	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	68,420	33,036	54.00
54.01	05401	ULTRASOUND	0.098049	49,435	4,847	54.01
56.00	05600	RADIOISOTOPE	0.092772	25,923	2,405	56.00
57.00	05700	CT SCAN	0.039829	275,494	10,973	57.00
58.00	05800	MRI	0.050643	90,524	4,584	58.00
60.00	06000	LABORATORY	0.100642	1,110,707	111,784	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	36,635	15,956	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	275,927	51,347	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	109,701	47,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	101,359	27,245	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	74,583	23,521	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	312,490	53,144	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	288,262	19,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	157,853	37,162	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	1,533,292	198,003	73.00
74.00	07400	RENAL DIALYSIS	0.142213	61,053	8,683	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.423697	8,598	3,643	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.650589	1,786	1,162	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.196971	343,102	67,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	33,570	18,232	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,369,381	956,025	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,369,381		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.097014	0	0	50.00
51.00	05100	RECOVERY ROOM	0.194073	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.842675	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016102	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.482847	0	0	54.00
54.01	05401	ULTRASOUND	0.098049	0	0	54.01
56.00	05600	RADIOISOTOPE	0.092772	0	0	56.00
57.00	05700	CT SCAN	0.039829	0	0	57.00
58.00	05800	MRI	0.050643	0	0	58.00
60.00	06000	LABORATORY	0.100642	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.435537	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.186090	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433144	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268794	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.315363	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.170066	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.069058	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235423	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.129136	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.142213	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.423697	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.650589	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.196971	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.543092	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 4:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	11,886,571	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,484,049	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	1,033,973	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	198,562	2.04
3.00	Managed Care Simulated Payments	9,760,248	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	70.29	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.36	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24.10	31.00
32.00	Sum of lines 30 and 31	28.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.69	33.00
34.00	Disproportionate share adjustment (see instructions)	519,359	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 4:01 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,257,607	756,886	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	940,621	190,777	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,131,398		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	19,253,912		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	19,253,912	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,371,280	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	364,622	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	20,989,814	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,989,814	61.00
62.00	Deductibles billed to program beneficiaries	1,667,448	62.00
63.00	Coinsurance billed to program beneficiaries	74,200	63.00
64.00	Allowable bad debts (see instructions)	161,843	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	105,198	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,086	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	19,353,364	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJ. PER PS&R	-520	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-93,777	70.93
70.94	HRR adjustment amount (see instructions)	-153,345	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 4:01 pm
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		207,427	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,898,295	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		18,611,453	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		286,842	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,485,837	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2022 4:01 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	11,886,571	11,886,571		11,886,571	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,484,049		4,484,049	4,484,049	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,033,973	1,033,973		1,033,973	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	198,562		198,562	198,562	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	9,760,248	7,003,856	2,756,392	9,760,248	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1269	0.1269	0.1269		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	519,359	377,102	142,257	519,359	11.00
11.01	Uncompensated care payments	36.00	1,131,398	940,621	190,777	1,131,398	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,253,912	14,238,267	5,015,645	19,253,912	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,253,912	14,238,267	5,015,645	19,253,912	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,371,280	1,025,642	345,638	1,371,280	16.00
17.00	Special add-on payments for new technologies	54.00	364,622	272,717	91,905	364,622	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			15,536,626	5,453,188	20,989,814	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2022 4:01 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,241,597	928,646	312,951	1,241,597	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	129,683	96,996	32,687	129,683	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,371,280	1,025,642	345,638	1,371,280	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-93,777	-70,140	-23,637	-93,777	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-153,345	-114,694	-38,651	-153,345	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		153,518	53,909	207,427	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/30/2022 4:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,249	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,452,441	2.00
3.00	OPPS payments	13,259,547	3.00
4.00	Outlier payment (see instructions)	26,890	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,249	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	20,067	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)	20,067	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)	20,067	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	15,818	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	4,249	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)	13,286,437	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	12,781	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,356,498	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	10,921,407	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	10,921,407	30.00
31.00	Primary payer payments	1,747	31.00
32.00	Subtotal (line 30 minus line 31)	10,919,660	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)	241,013	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	156,658	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	108,159	36.00
37.00	Subtotal (see instructions)	11,076,318	37.00
38.00	MSP-LCC reconciliation amount from PS&R	150	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)	11,076,168	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	11,080,102	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)	-3,934	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2022 4:01 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		18,611,453		11,080,102	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)		18,611,453		11,080,102	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		286,842		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3,934	6.02
7.00	Total Medicare program liability (see instructions)		18,898,295		11,076,168	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: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/30/2022 4:01 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-2 | Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2022 4:01 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,089,500	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,089,500	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,089,500	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	2,296,189		8.00
9.00	Ancillary service charges	6,369,381	7,341,306	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	8,665,570	7,341,306	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	8,665,570	7,341,306	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,665,570	6,251,806	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,089,500	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,089,500	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,089,500	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,089,500	36.00
37.00	REMOVE SETTLEMENT	0	-1,089,500	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G | Date/Time Prepared: 5/30/2022 4:01 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	-6,034	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	44,683,735	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,467,470	0	0	0	6.00
7.00	Inventory	4,106,221	0	0	0	7.00
8.00	Prepaid expenses	2,297,777	0	0	0	8.00
9.00	Other current assets	118,237	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)	38,732,466	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,041,255	0	0	0	12.00
13.00	Land improvements	2,284,450	0	0	0	13.00
14.00	Accumulated depreciation	-951,957	0	0	0	14.00
15.00	Buildings	134,431,276	0	0	0	15.00
16.00	Accumulated depreciation	-21,903,340	0	0	0	16.00
17.00	Leasehold improvements	923,148	0	0	0	17.00
18.00	Accumulated depreciation	-317,007	0	0	0	18.00
19.00	Fixed equipment	2,603,684	0	0	0	19.00
20.00	Accumulated depreciation	-1,143,657	0	0	0	20.00
21.00	Automobiles and trucks	101,790	0	0	0	21.00
22.00	Accumulated depreciation	-101,790	0	0	0	22.00
23.00	Major movable equipment	40,950,160	0	0	0	23.00
24.00	Accumulated depreciation	-10,535,209	0	0	0	24.00
25.00	Minor equipment depreciable	7,973,308	0	0	0	25.00
26.00	Accumulated depreciation	-3,418,203	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)	153,937,908	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	11,566,593	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,566,593	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	204,236,967	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,718,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,176,296	0	0	0	38.00
39.00	Payroll taxes payable	-6,463	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,996,013	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	111,971,824	0	0	0	43.00
44.00	Other current liabilities	2,518,815	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	129,375,337	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,890,565	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,890,565	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	140,265,902	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	63,971,065				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)	63,971,065	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	204,236,967	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-1 | Date/Time Prepared: 5/30/2022 4:01 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		30,578,516		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,392,549				2.00
3.00	Total (sum of line 1 and line 2)		63,971,065		0		3.00
4.00	FUND BALANCE TIE	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		63,971,065		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)		63,971,065		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	FUND BALANCE TIE		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2021 To 12/31/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2022 4:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	57,448,089		57,448,089	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	57,448,089		57,448,089	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	14,929,321		14,929,321	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)	14,929,321		14,929,321	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72,377,410		72,377,410	17.00
18.00	Ancillary services	223,866,233	396,591,155	620,457,388	18.00
19.00	Outpatient services	13,186,510	29,918,378	43,104,888	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	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)	309,430,153	426,509,533	735,939,686	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		154,633,183		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)		154,633,183		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prepared: 5/30/2022 4:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	735,939,686	1.00
2.00	Less contractual allowances and discounts on patients' accounts	555,019,064	2.00
3.00	Net patient revenues (line 1 minus line 2)	180,920,622	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	154,633,183	4.00
5.00	Net income from service to patients (line 3 minus line 4)	26,287,439	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,288,264	24.00
24.50	COVID-19 PHE Funding	5,816,846	24.50
25.00	Total other income (sum of lines 6-24)	7,105,110	25.00
26.00	Total (line 5 plus line 25)	33,392,549	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	33,392,549	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0006	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/30/2022 4:01 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,241,597	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		129,683	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		61.34	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,371,280	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00