

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: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/27/2022 9:02 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/27/2022	Time: 9:02 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for Full or "L" for Low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 METHODIST HOSPITALS, INC (15-0002) 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	Matt Doyle	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Matt Doyle		2
3	Signatory Title	CEO		3
4	Date	(Dated when report is electronic)		4

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,103,412	-371,089	0	-1,147,059	1.00
2.00 Subprovider - IPF	0	18,228	0		-92,197	2.00
3.00 Subprovider - IRF	0	27,334	0		-39,285	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	1,148,974	-371,089	0	-1,278,541	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:02 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 600 GRANT STREET			PO Box:						1.00	
2.00	City: GARY			State: IN		Zip Code: 46402		County: LAKE		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX	
Hospital and Hospital -Based Component Identification:											
3.00	Hospital		METHODIST HOSPITALS, INC	150002	23844	1	01/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		GERIATRIC PSYCH	15S002	23844	4	01/01/2012	N	P	0	4.00
5.00	Subprovider - IRF		REHABILITATION	15T002	23844	5	01/01/1984	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital -Based SNF										9.00
10.00	Hospital -Based NF										10.00
11.00	Hospital -Based OLTC										11.00
12.00	Hospital -Based HHA		METHODIST HOME CARE SERVICES	157536	23844		02/12/2002	N	P	0	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital -Based Hospice										14.00
15.00	Hospital -Based Health Clinic - RHC										15.00
16.00	Hospital -Based Health Clinic - FQHC										16.00
17.00	Hospital -Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021			20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		N	22.03	
22.04	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.										
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)					N	N		N	22.04	
22.04	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.										
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: 15-0002			Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:02 am		
		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.	3,316	4,936	0	1,690	16,075	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	129	354	0	0	220		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)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	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.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria 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 adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	2		60.01	
		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		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:02 am		
		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.	Y				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.	Y				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
		1.00				
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
		V			XIX	
		1.00			2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, 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. 1? 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. 1, 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. 1 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)	N				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:02 am
		V	XIX	
		1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
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
				Respiratory
				4.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00
				1.00
				2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
				1.00
				2.00
				3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		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:	1,190,494	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
DO NOT USE THIS LINE				
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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:02 am	
		1.00	2.00				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	
						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	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	
						169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/27/2022 9:02 am
		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. 1, 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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 9:02 am	
		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				
		1.00	2.00				
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)	N					3.00
		Y/N	Type				
		1.00	2.00				
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.	Y					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.	Y					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.	Y					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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/25/2022	Y	02/25/2022		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: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/27/2022 9:02 am	
		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 relieved 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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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?		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0002

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2022 9:02 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
	Line Number				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	348	127,020	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)		348	127,020	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	33	12,045	0.00	0	8.00
8.01 NEONATAL ICU	31.01	36	13,140	0.00	0	8.01
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)		417	152,205	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		453			0	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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	18,462	3,312	66,690			1.00
2.00 HMO and other (see instructions)	23,224	22,641				2.00
3.00 HMO IPF Subprovider	0	311				3.00
4.00 HMO IRF Subprovider	0	574				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)	18,462	3,312	66,690			7.00
8.00 INTENSIVE CARE UNIT	2,984	0	9,195			8.00
8.01 NEONATAL ICU	0	0	2,460			8.01
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		0	2,056			13.00
14.00 Total (see instructions)	21,446	3,312	80,401	0.00	1,827.27	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	422	58	1,239	0.00	11.47	16.00
17.00 SUBPROVIDER - IRF	1,987	129	4,300	0.00	23.27	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	6,253	1,136	21,324	0.00	25.98	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			302			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	1,887.99	27.00
28.00 Observation Bed Days		2,435	14,472			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	64	70			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: 15-0002

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	2,997	424	11,507	1.00
2.00 HMO and other (see instructions)				2,573	3,576		2.00
3.00 HMO IPF Subprovider					30		3.00
4.00 HMO IRF Subprovider					43		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
8.01 NEONATAL ICU							8.01
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	2,997	424		11,507	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	35	5		124	16.00
17.00 SUBPROVIDER - IRF	0.00	0	145	8		304	17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2022 9:02 am

	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	148,935,514	-398,181	148,537,333	3,933,303.00	37.76
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		72,344	0	72,344	434.00	166.69
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		27,770,060	1,104,797	28,874,857	565,650.00	51.05
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		23,443,361	0	23,443,361	240,654.00	97.42
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		598,074	0	598,074	4,140.00	144.46
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		32,976,576	0	32,976,576		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,846,714	0	5,846,714		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		7,467	0	7,467		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2022 9:02 am

	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 2,242,852	-109,472	2,133,380	34,960.00	61.02	26.00
27.00	Administrative & General	5.00 22,408,421	-1,345,193	21,063,228	628,449.00	33.52	27.00
28.00	Administrative & General under contract (see inst.)	6,941,665	0	6,941,665	109,168.00	63.59	28.00
29.00	Maintenance & Repairs	6.00 0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00 3,734,020	-20,212	3,713,808	149,551.00	24.83	30.00
31.00	Laundry & Linen Service	8.00 0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00 4,146,697	-14,834	4,131,863	244,301.00	16.91	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00 3,305,829	-1,994,130	1,311,699	53,445.00	24.54	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00 263,420	1,982,607	2,246,027	87,522.00	25.66	36.00
37.00	Maintenance of Personnel	12.00 0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00 4,495,332	-27,930	4,467,402	66,480.00	67.20	38.00
39.00	Central Services and Supply	14.00 595,750	1,211	596,961	29,601.00	20.17	39.00
40.00	Pharmacy	15.00 0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00 2,094,369	-3,339	2,091,030	84,352.00	24.79	41.00
42.00	Social Service	17.00 469	423,230	423,699	13,973.00	30.32	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2022 9:02 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries 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)	155,804,835	-398,181	155,406,654	4,042,037.00	38.45	1.00
2.00	Excluded area salaries (see instructions)	27,770,060	1,104,797	28,874,857	565,650.00	51.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)	128,034,775	-1,502,978	126,531,797	3,476,387.00	36.40	3.00
4.00	Subtotal other wages & related costs (see inst.)	24,041,435	0	24,041,435	244,794.00	98.21	4.00
5.00	Subtotal wage-related costs (see inst.)	32,976,576	0	32,976,576	0.00	26.06	5.00
6.00	Total (sum of lines 3 thru 5)	185,052,786	-1,502,978	183,549,808	3,721,181.00	49.33	6.00
7.00	Total overhead cost (see instructions)	50,228,824	-1,108,062	49,120,762	1,501,802.00	32.71	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2022 9:02 am
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			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		2,058,734	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		3,200,000	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)		18,063,946	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		3,089,679	9.00
10.00	Dental, Hearing and Vision Plan		769,960	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		370,888	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		732,561	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		10,253,898	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		80,002	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		211,088	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		38,830,756	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: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/27/2022 9:02 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	23,443,361	38,830,756	1.00
2.00	Hospital	23,443,361	38,830,756	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 15-0002 Component CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet S-4 Date/Time Prepared: 5/27/2022 9:02 am
			Home Health Agency I	PPS

					1.00	
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0.00	County					0.00
		Title V	Title XVIII	Title XIX	Other	Total
		1.00	2.00	3.00	4.00	5.00

HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	239.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
				Staff	Contract	Total	
Enter the number of hours in your normal work week							
				0	1.00	2.00	3.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			7.84	0.00	7.84	5.00
6.00	Direct Nursing Service			10.30	0.00	10.30	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.38	0.00	4.38	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.56	0.00	1.56	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.05	0.00	0.05	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.86	0.00	1.86	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00

						CBSA Data	
						1.00	

HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					23844	20.00

						Full Episodes	
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,952	492	58	13	3,515	21.00
22.00	Skilled Nursing Visit Charges	621,276	103,752	12,226	2,743	739,997	22.00
23.00	Physical Therapy Visits	1,122	296	15	3	1,436	23.00
24.00	Physical Therapy Visit Charges	258,034	68,320	3,465	693	330,512	24.00
25.00	Occupational Therapy Visits	406	208	3	0	617	25.00
26.00	Occupational Therapy Visit Charges	94,458	48,380	699	0	143,537	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	6	3	0	0	9	29.00
30.00	Medical Social Service Visit Charges	2,022	1,011	0	0	3,033	30.00
31.00	Home Health Aide Visits	546	129	0	1	676	31.00
32.00	Home Health Aide Visit Charges	51,654	12,225	0	95	63,974	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,032	1,128	76	17	6,253	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,027,444	233,688	16,390	3,531	1,281,053	35.00
36.00	Total Number of Episodes (standard/non outlier)	428		53	2	483	36.00
37.00	Total Number of Outlier Episodes		44		0	44	37.00
38.00	Total Non-Routine Medical Supply Charges	157,971	43,706	5,070	350	207,097	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/27/2022 9:02 am
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				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)			0.223765	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			99,748,177	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?			N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			37,767,706	5.00	
6.00	Medicaid charges			571,252,321	6.00	
7.00	Medicaid cost (line 1 times line 6)			127,826,276	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)	18,040,428	651,473	18,691,901	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,036,816	651,473	4,688,289	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	4,036,816	651,473	4,688,289	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)			17,703,262	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			650,896	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,001,379	27.01	
28.00	Non-Medicare bad debt expense (see instructions)			16,701,883	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			4,087,780	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			8,776,069	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,776,069	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepared: 5/27/2022 9:02 am		
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT		0	0	19,027,402	19,027,402	1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2,242,852	29,643,790	31,886,642	284,449	32,171,091	4.00	
5.01 00550 DATA PROCESSING	4,556,912	9,121,617	13,678,529	-1,405,791	12,272,738	5.01	
5.02 00560 PURCHASING RECEIVING AND STORES	933,907	2,481,598	3,415,505	-93,831	3,321,674	5.02	
5.03 00570 ADMINITTING	2,445,747	496,400	2,942,147	1,476	2,943,623	5.03	
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	3,105,539	4,679,573	7,785,112	-1,190,520	6,594,592	5.04	
5.05 00590 OTHER A&G	10,881,652	22,401,689	33,283,341	-14,144,027	19,139,314	5.05	
5.06 00592 PATIENT TRANSPORTATION	484,664	54,808	539,472	-22,807	516,665	5.06	
7.00 00700 OPERATION OF PLANT	3,734,020	9,283,962	13,017,982	6,001,916	19,019,898	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	1,309,444	1,309,444	0	1,309,444	8.00	
9.00 00900 HOUSEKEEPING	4,146,697	1,156,002	5,302,699	-202,769	5,099,930	9.00	
10.00 01000 DIETARY	3,305,829	2,997,825	6,303,654	-3,940,256	2,363,398	10.00	
11.00 01100 CAFETERIA	263,420	32,236	295,656	3,857,590	4,153,246	11.00	
13.00 01300 NURSING ADMINISTRATION	4,495,332	1,446,265	5,941,597	-153,926	5,787,671	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	595,750	2,488,424	3,084,174	-543,464	2,540,710	14.00	
15.00 01500 PHARMACY	0	16,814,470	16,814,470	-11,156,074	5,658,396	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	2,094,369	836,100	2,930,469	-7,623	2,922,846	16.00	
17.00 01700 SOCIAL SERVICE	0	0	0	423,230	423,230	17.00	
17.01 01701 STAFF EDUCATION	0	0	0	0	0	17.01	
17.02 01702 MEDICAL EDUCATION	469	10,424	10,893	-547	10,346	17.02	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	254,151	254,151	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	31,168	31,168	22.00	
23.00 02300 PARAMED PROGRAM	414,046	87,904	501,950	287,422	789,372	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	25,612,346	22,602,663	48,215,009	-661,690	47,553,319	30.00	
31.00 03100 INTENSIVE CARE UNIT	7,924,732	3,785,477	11,710,209	-742,355	10,967,854	31.00	
31.01 03101 NEONATAL ICU	1,488,278	1,377,590	2,865,868	-40,745	2,825,123	31.01	
40.00 04000 SUBPROVIDER - I PF	928,913	88,071	1,016,984	-10,350	1,006,634	40.00	
41.00 04100 SUBPROVIDER - I RF	1,843,322	325,679	2,169,001	-42,013	2,126,988	41.00	
43.00 04300 NURSERY	1,273,393	375,090	1,648,483	-129,303	1,519,180	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	4,309,232	27,024,168	31,333,400	-15,403,975	15,929,425	50.00	
50.01 05001 ENDOSCOPY	718,482	893,723	1,612,205	-435,035	1,177,170	50.01	
51.00 05100 RECOVERY ROOM	974,092	189,292	1,163,384	-13,598	1,149,786	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,256,438	1,172,320	4,428,758	-260,165	4,168,593	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,237,488	2,247,927	4,485,415	-854,031	3,631,384	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	1,276,422	635,508	1,911,930	-214,886	1,697,044	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	499,222	2,830,976	3,330,198	-648,090	2,682,108	55.00	
55.01 05501 INFUSION CENTER	18,571	37,887	56,458	-9,194	47,264	55.01	
56.00 05600 RADIOISOTOPE	550,247	1,314,051	1,864,298	-192,383	1,671,915	56.00	
57.00 05700 CT SCAN	1,193,395	1,045,481	2,238,876	-164,122	2,074,754	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	462,789	892,732	1,355,521	-539,905	815,616	58.00	
59.00 05900 CARDIAC CATHETERIZATION	2,511,807	6,558,762	9,070,569	-5,698,205	3,372,364	59.00	
60.00 06000 LABORATORY	3,820,133	8,547,128	12,367,261	-111,569	12,255,692	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,170,472	355,928	1,526,400	-11,062	1,515,338	62.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	2,775,997	1,386,925	4,162,922	-304,245	3,858,677	65.00	
66.00 06600 PHYSICAL THERAPY	1,377,198	122,174	1,499,372	-5,776	1,493,596	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,103,581	96,257	1,199,838	-809	1,199,029	67.00	
68.00 06800 SPEECH PATHOLOGY	456,545	48,722	505,267	-45	505,222	68.00	
69.00 06900 ELECTROCARDIOLOGY	645,482	313,854	959,336	-171,704	787,632	69.00	
69.01 06901 CARDIAC REHAB	394,960	429,141	824,101	-224,759	599,342	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	1,074,313	10,387,950	11,462,263	-10,089,267	1,372,996	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,702,025	13,702,025	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,677,336	11,677,336	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	360,465	3,669,544	4,030,009	17,621,862	21,651,871	73.00	
74.00 07400 RENAL DIALYSIS	352	2,308,691	2,309,043	-1,898	2,307,145	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	2,745,082	2,943,965	5,689,047	-200,190	5,488,857	90.00	
91.00 09100 EMERGENCY	7,646,781	8,402,466	16,049,247	-1,152,314	14,896,933	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	2,167,399	428,951	2,596,350	-27,710	2,568,640	101.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	126,519,134	218,181,624	344,700,758	1,946,999	346,647,757	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	733	733	-576	157	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	22,321,602	14,696,718	37,018,320	-239,801	36,778,519	192.00	
192.01 19201 OTHER NON-REIMBURSABLE	0	2,066,233	2,066,233	-1,706,622	359,611	192.01	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet A Date/Time Prepared: 5/27/2022 9:02 am		
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		
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	94,778	76,093	170,871	0	170,871	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	148,935,514	235,021,401	383,956,915	0	383,956,915	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002

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

Worksheet A
Date/Time Prepared:
5/27/2022 9:02 am

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	-1,954,795	17,072,607	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	551,799	32,722,890	4.00
5.01	00550	DATA PROCESSING	-278,425	11,994,313	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	3,321,674	5.02
5.03	00570	ADMITTING	0	2,943,623	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-31,968	6,562,624	5.04
5.05	00590	OTHER A&G	-317,554	18,821,760	5.05
5.06	00592	PATIENT TRANSPORTATION	0	516,665	5.06
7.00	00700	OPERATION OF PLANT	0	19,019,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,309,444	8.00
9.00	00900	HOUSEKEEPING	-5,020	5,094,910	9.00
10.00	01000	DIETARY	-853	2,362,545	10.00
11.00	01100	CAFETERIA	-726,330	3,426,916	11.00
13.00	01300	NURSING ADMINISTRATION	-7,930	5,779,741	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,540,710	14.00
15.00	01500	PHARMACY	0	5,658,396	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-298,069	2,624,777	16.00
17.00	01700	SOCIAL SERVICE	0	423,230	17.00
17.01	01701	STAFF EDUCATION	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	10,346	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	254,151	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	31,168	22.00
23.00	02300	PARAMED PROGRAM	-144,815	644,557	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,147,142	44,406,177	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,967,854	31.00
31.01	03101	NEONATAL ICU	-960,458	1,864,665	31.01
40.00	04000	SUBPROVIDER - I/PF	0	1,006,634	40.00
41.00	04100	SUBPROVIDER - I/RF	0	2,126,988	41.00
43.00	04300	NURSERY	0	1,519,180	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-7,737,458	8,191,967	50.00
50.01	05001	ENDOSCOPY	0	1,177,170	50.01
51.00	05100	RECOVERY ROOM	0	1,149,786	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,168,593	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,631,384	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	-2,160	1,694,884	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-140,747	2,541,361	55.00
55.01	05501	INFUSION CENTER	0	47,264	55.01
56.00	05600	RADIOISOTOPE	0	1,671,915	56.00
57.00	05700	CT SCAN	-4,488	2,070,266	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	815,616	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,372,364	59.00
60.00	06000	LABORATORY	-60,422	12,195,270	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	-58,649	1,456,689	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,400	3,879,077	65.00
66.00	06600	PHYSICAL THERAPY	0	1,493,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,199,029	67.00
68.00	06800	SPEECH PATHOLOGY	0	505,222	68.00
69.00	06900	ELECTROCARDIOLOGY	0	787,632	69.00
69.01	06901	CARDIAC REHAB	-112,007	487,335	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,214	1,371,782	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,702,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,677,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-175,722	21,476,149	73.00
74.00	07400	RENAL DIALYSIS	0	2,307,145	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-85,648	5,403,209	90.00
91.00	09100	EMERGENCY	-2,215,891	12,681,042	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,568,640	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,895,566	328,752,191	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	157	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-8,393,064	28,385,455	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	359,611	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	-100,002	70,869	192.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet A Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation				
			6.00	7.00				
193.00	19300	NONPAID WORKERS	0	0				193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-26,388,632	357,568,283				200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - CAFETERIA						
1.00	CAFETERIA	11.00	1,983,510	1,875,262	1.00	
	O		1,983,510	1,875,262		
B - CLINICAL TRAINING COST						
1.00	PARAMED ED PROGRAM	23.00	290,601	0	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	
	O		290,601	0		
C - SOCIAL WORKERS						
1.00	SOCIAL SERVICE	17.00	423,230	0	1.00	
	O		423,230	0		
E - RESIDENTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	254,151	1.00	
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	31,168	2.00	
	O		0	285,319		
F - MED SUPPLY						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,702,025	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,677,336	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	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
37.00		0.00	0	0	37.00	
38.00		0.00	0	0	38.00	
39.00		0.00	0	0	39.00	
40.00		0.00	0	0	40.00	
41.00		0.00	0	0	41.00	
42.00		0.00	0	0	42.00	
43.00		0.00	0	0	43.00	
44.00		0.00	0	0	44.00	
45.00		0.00	0	0	45.00	
46.00		0.00	0	0	46.00	
47.00		0.00	0	0	47.00	
	O		0	25,379,361		

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
G - LIGHT DUTY					
1.00	ADMINISTRATIVE	5.03	7,390	0	1.00
2.00	HOUSEKEEPING	9.00	4,273	0	2.00
3.00	DIETARY	10.00	5,913	0	3.00
4.00	NURSING ADMINISTRATION	13.00	1,004	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	2,038	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	43,595	0	6.00
7.00	SUBPROVIDER - IRF	41.00	171	0	7.00
8.00	OPERATING ROOM	50.00	13,652	0	8.00
9.00	ENDOSCOPY	50.01	2,589	0	9.00
10.00	RADIOISOTOPE	56.00	17,592	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	9,187	0	11.00
12.00	EMERGENCY	91.00	2,068	0	12.00
0			109,472	0	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,048,826	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	2,048,826	
I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,157,522	1.00
2.00	OPERATION OF PLANT	7.00	0	5,253,282	2.00
0			0	11,410,804	
J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,950,733	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	17,950,733	
K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5.05	0	34,500	1.00
2.00	CLINIC	90.00	0	94,556	2.00
0			0	129,056	
L - PSTD RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	398,181	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	398,181	
M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,821,054	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
					10,821,054	
N - DEPT 9101 RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	882,307	269,396		1.00
			882,307	269,396		
O - UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	1,124,448		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
					1,124,448	
P - C SECTION RECLASS						
1.00	OPERATING ROOM	50.00	45,475	0		1.00
			45,475	0		
500.00	Grand Total: Increases		3,734,595	71,692,440		500.00

RECLASSIFICATIONS

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Period:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	1,983,510	1,875,262	0		1.00
	O		1,983,510	1,875,262			
B - CLINICAL TRAINING COST							
1.00	INTENSIVE CARE UNIT	31.00	6,625	0	0		1.00
2.00	OPERATING ROOM	50.00	20,828	0	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	3,643	0	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	25,133	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	10,407	0	0		5.00
6.00	EMERGENCY	91.00	223,965	0	0		6.00
	O		290,601	0			
C - SOCIAL WORKERS							
1.00	OTHER A&G	5.05	423,230	0	0		1.00
	O		423,230	0			
E - RESIDENTS							
1.00	EMERGENCY	91.00	0	285,319	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	285,319			
F - MED SUPPLY							
1.00	PURCHASING RECEIVING AND STORES	5.02		45,920	0		1.00
2.00	ADMINISTRATIVE	5.03		98	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04		6	0		3.00
4.00	OTHER A&G	5.05		706	0		4.00
5.00	PATIENT TRANSPORTATION	5.06		13	0		5.00
6.00	OPERATION OF PLANT	7.00		215	0		6.00
7.00	HOUSEKEEPING	9.00		1,726	0		7.00
8.00	DIETARY	10.00		51	0		8.00
9.00	CAFETERIA	11.00		3	0		9.00
10.00	NURSING ADMINISTRATION	13.00		2,592	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00		143,914	0		11.00
12.00	PHARMACY	15.00		5,396	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00		16	0		13.00
14.00	MEDICAL EDUCATION	17.02		547	0		14.00
15.00	PARAMEDICAL PROGRAM	23.00		321	0		15.00
16.00	ADULTS & PEDIATRICS	30.00		485,595	0		16.00
17.00	INTENSIVE CARE UNIT	31.00		166,876	0		17.00
18.00	NEONATAL ICU	31.01		1,012	0		18.00
19.00	SUBPROVIDER - IRF	41.00		26,929	0		19.00
20.00	NURSERY	43.00		42,811	0		20.00
21.00	OPERATING ROOM	50.00		14,596,716	0		21.00
22.00	ENDOSCOPY	50.01		328,516	0		22.00
23.00	RECOVERY ROOM	51.00		12,595	0		23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00		47,403	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00		2,604	0		25.00
26.00	RADIOLOGY - ULTRASOUND	54.01		54,423	0		26.00
27.00	RADIOLOGY-THERAPEUTIC	55.00		18,732	0		27.00
28.00	INFUSION CENTER	55.01		8,160	0		28.00
29.00	RADIOISOTOPE	56.00		680	0		29.00
30.00	CT SCAN	57.00		41,300	0		30.00
31.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		340	0		31.00
32.00	CARDIAC CATHETERIZATION	59.00		5,530,016	0		32.00
33.00	LABORATORY	60.00		6,614	0		33.00
34.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00		286	0		34.00
35.00	RESPIRATORY THERAPY	65.00		183,543	0		35.00
36.00	PHYSICAL THERAPY	66.00		884	0		36.00
37.00	OCCUPATIONAL THERAPY	67.00		367	0		37.00
38.00	SPEECH PATHOLOGY	68.00		45	0		38.00
39.00	ELECTROCARDIOLOGY	69.00		2,944	0		39.00
40.00	CARDIAC REHAB	69.01		942	0		40.00
41.00	ELECTROENCEPHALOGRAPHY	70.00		2,781,113	0		41.00
42.00	DRUGS CHARGED TO PATIENTS	73.00		294,067	0		42.00
43.00	RENAL DIALYSIS	74.00		1,753	0		43.00
44.00	CLINIC	90.00		126,575	0		44.00
45.00	EMERGENCY	91.00		341,265	0		45.00
46.00	HOME HEALTH AGENCY	101.00		27,710	0		46.00
47.00	PHYSICIANS' PRIVATE OFFICES	192.00		45,021	0		47.00
	O		0	25,379,361			

RECLASSIFICATIONS

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Period:
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To 12/31/2021

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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
G - LIGHT DUTY							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	109,472	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	0		109,472	0			
H - INTEREST EXPENSE							
1.00	OTHER A&G	5.05	0	2,027,993	11		1.00
2.00	OPERATING ROOM	50.00	0	19,287	0		2.00
3.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,546	0		3.00
	0		0	2,048,826			
I - CORPORATE EXPENSE							
1.00	OTHER A&G	5.05	0	11,410,804	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	11,410,804			
J - DRUG EXPENSE							
1.00	PHARMACY	15.00	0	10,863,011	0		1.00
2.00	INFUSION CENTER	55.01	0	6	0		2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,087,716	0		3.00
	0		0	17,950,733			
K - PHYSICIAN RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	129,056	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	129,056			
L - PSTD RECLASS							
1.00	ADMINISTRATIVE	5.03	4,177	0	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	6,632	0	0		2.00
3.00	OTHER A&G	5.05	25,636	0	0		3.00
4.00	PATIENT TRANSPORTATION	5.06	10,601	0	0		4.00
5.00	OPERATION OF PLANT	7.00	20,212	0	0		5.00
6.00	HOUSEKEEPING	9.00	19,107	0	0		6.00
7.00	DIETARY	10.00	16,533	0	0		7.00
8.00	CAFETERIA	11.00	903	0	0		8.00
9.00	NURSING ADMINISTRATION	13.00	28,934	0	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	827	0	0		10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	3,339	0	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	44,139	0	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	17,752	0	0		13.00
14.00	SUBPROVIDER - I RF	41.00	7,259	0	0		14.00
15.00	NURSERY	43.00	19,759	0	0		15.00
16.00	OPERATING ROOM	50.00	47,708	0	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	3,846	0	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	10,888	0	0		18.00
19.00	RADIOLOGY-THERAPEUTIC	55.00	8,186	0	0		19.00
20.00	CT SCAN	57.00	1,292	0	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	6,023	0	0		21.00
22.00	LABORATORY	60.00	17,879	0	0		22.00
23.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	892	0	0		23.00
24.00	RESPIRATORY THERAPY	65.00	2,343	0	0		24.00
25.00	PHYSICAL THERAPY	66.00	3,859	0	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	3,758	0	0		26.00
27.00	CLINIC	90.00	2,508	0	0		27.00
28.00	EMERGENCY	91.00	2,166	0	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	61,023	0	0		29.00
	0		398,181	0			
M - DEPRECIATION RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,260	9		1.00
2.00	DATA PROCESSING	5.01	0	1,246,818	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	47,911	0		3.00
4.00	ADMINISTRATIVE	5.03	0	1,639	0		4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	4,374	0		5.00
6.00	OTHER A&G	5.05	0	290,158	0		6.00

RECLASSIFICATIONS

Provider CCN: 15-0002

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

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		Decreases			Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
7.00	PATIENT TRANSPORTATION	5.06	0	12,193	0	7.00
8.00	OPERATION OF PLANT	7.00	0	355,387	0	8.00
9.00	HOUSEKEEPING	9.00	0	57,066	0	9.00
10.00	DIETARY	10.00	0	70,813	0	10.00
11.00	CAFETERIA	11.00	0	276	0	11.00
12.00	NURSING ADMINISTRATION	13.00	0	123,404	0	12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	0	400,761	0	13.00
14.00	PHARMACY	15.00	0	287,667	0	14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,268	0	15.00
16.00	PARAMED ED PROGRAM	23.00	0	2,858	0	16.00
17.00	ADULTS & PEDIATRICS	30.00	0	175,551	0	17.00
18.00	INTENSIVE CARE UNIT	31.00	0	551,102	0	18.00
19.00	NEONATAL ICU	31.01	0	39,733	0	19.00
20.00	SUBPROVIDER - IPF	40.00	0	10,350	0	20.00
21.00	SUBPROVIDER - IRF	41.00	0	7,996	0	21.00
22.00	NURSERY	43.00	0	66,733	0	22.00
23.00	OPERATING ROOM	50.00	0	778,563	0	23.00
24.00	ENDOSCOPY	50.01	0	109,108	0	24.00
25.00	RECOVERY ROOM	51.00	0	1,003	0	25.00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	138,308	0	26.00
27.00	RADIOLOGY-DIAGNOSTIC	54.00	0	840,539	0	27.00
28.00	RADIOLOGY - ULTRASOUND	54.01	0	160,463	0	28.00
29.00	RADIOLOGY-THERAPEUTIC	55.00	0	619,626	0	29.00
30.00	INFUSION CENTER	55.01	0	1,028	0	30.00
31.00	RADIOISOTOPE	56.00	0	209,295	0	31.00
32.00	CT SCAN	57.00	0	121,530	0	32.00
33.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	539,565	0	33.00
34.00	CARDIAC CATHETERIZATION	59.00	0	158,523	0	34.00
35.00	LABORATORY	60.00	0	87,076	0	35.00
36.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	9,884	0	36.00
37.00	RESPIRATORY THERAPY	65.00	0	107,952	0	37.00
38.00	PHYSICAL THERAPY	66.00	0	1,033	0	38.00
39.00	OCCUPATIONAL THERAPY	67.00	0	442	0	39.00
40.00	ELECTROCARDIOLOGY	69.00	0	177,947	0	40.00
41.00	CARDIAC REHAB	69.01	0	174,728	0	41.00
42.00	ELECTROENCEPHALOGRAPHY	70.00	0	216,680	0	42.00
43.00	DRUGS CHARGED TO PATIENTS	73.00	0	34,804	0	43.00
44.00	RENAL DIALYSIS	74.00	0	145	0	44.00
45.00	CLINIC	90.00	0	165,663	0	45.00
46.00	EMERGENCY	91.00	0	301,667	0	46.00
47.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	576	0	47.00
48.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	816,886	0	48.00
49.00	OTHER NON-REIMBURSABLE	192.01	0	1,286,702	0	49.00
	O		0	10,821,054		
N - DEPT 9101 RECLASS						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	882,307	269,396	0	1.00
	O		882,307	269,396		
O - UTILITIES RECLASS						
1.00	DATA PROCESSING	5.01	0	158,973	0	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	27,805	0	2.00
3.00	HOUSEKEEPING	9.00	0	129,143	0	3.00
4.00	CARDIAC REHAB	69.01	0	49,089	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	339,518	0	5.00
6.00	OTHER NON-REIMBURSABLE	192.01	0	419,920	0	6.00
	O		0	1,124,448		
P - C SECTION RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	45,475	0	0	1.00
	O		45,475	0		
500.00	Grand Total: Decreases		4,132,776	71,294,259		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,373,674	0	0	0	1.00
2.00	Land Improvements	6,896,457	61,750	0	61,750	2.00
3.00	Buildings and Fixtures	308,285,957	1,071,781	0	1,071,781	3.00
4.00	Building Improvements	1,230,154	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	199,068,926	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	520,855,168	1,133,531	0	1,133,531	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	520,855,168	1,133,531	0	1,133,531	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,373,674	0			1.00
2.00	Land Improvements	6,958,207	0			2.00
3.00	Buildings and Fixtures	309,357,738	0			3.00
4.00	Building Improvements	1,230,154	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	211,798,957	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	534,718,730	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	534,718,730	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description	SUMMARY OF CAPITAL					
	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

Cost Center Description	SUMMARY OF CAPITAL		
	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
	14.00	15.00	

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0002

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	534,718,730	0	534,718,730	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	534,718,730	0	534,718,730	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	17,072,607	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,072,607	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	17,072,607	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	17,072,607	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	5.00
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,048,826	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00		2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-14,276,957			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-726,330	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employees and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-298,069	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	-853	DIETARY	10.00	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	94,031	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
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 DATA PROCESSING OTHER INCOME	B	-278,425		DATA PROCESSING	5.01	0 33.00
33.01 CASH, A/R, COLLECTIONS OTHER INCOME	B	-31,968		CASHIERING/ACCOUNTS RECEIVABLE	5.04	0 33.01
33.02 A&G OTHER INCOME	B	-299,385		OTHER A&G	5.05	0 33.02
33.03 ENVIRONMENTAL SERVICES OTHER INCOME	B	-5,020		HOUSEKEEPING	9.00	0 33.03
33.04 NURSING ADMIN OTHER INCOME	B	-4,200		NURSING ADMINISTRATION	13.00	0 33.04
33.05 PARAMED PROGRAM OTHER INCOME	B	-30,859		PARAMED PROGRAM	23.00	0 33.05
33.06 ADULTS & PEDI OTHER INCOME	B	-15		ADULTS & PEDIATRICS	30.00	0 33.06
33.07 LAB OTHER INCOME	B	-60,422		LABORATORY	60.00	0 33.07
33.08 BLOOD OTHER INCOME	B	-58,649		WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0 33.08
33.09 RESPIRATORY THERAPY OTHER INCOME	B	-350		RESPIRATORY THERAPY	65.00	0 33.09
33.10 CARDIAC REHAB OTHER INCOME	B	-112,007		CARDIAC REHAB	69.01	0 33.10
33.11 ELECTROCEPHALOGRAPHY OTHER INCOME	B	-1,214		ELECTROENCEPHALOGRAPHY	70.00	0 33.11
33.12 EMT OFFSET	B	-20,956		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.12
33.13 EMT OFFSET	B	-113,956		PARAMED PROGRAM	23.00	0 33.13
33.14 DUES/LOBBYING	A	-18,169		OTHER A&G	5.05	0 33.14
33.15 RX PROGRAM	A	-175,722		DRUGS CHARGED TO PATIENTS	73.00	0 33.15
33.16 PENSION ADJUSTMENT	A	572,755		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.16
33.17 PHYSICIAN OFFICE	B	-596,335		PHYSICIANS' PRIVATE OFFICES	192.00	0 33.17
33.18 FAMILY HEALTH	B	-100,002		FAMILY HEALTH/GARY COMM HEALTH	192.02	0 33.18
33.19 PHYSICIAN OFFSET	A	-7,796,729		PHYSICIANS' PRIVATE OFFICES	192.00	0 33.19
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,388,632				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0002

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2022 9:02 am

	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	13.00	NURSING ADMINISTRATION	3,730	3,730	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	3,147,127	3,147,127	0	211,500	0	2.00
3.00	31.01	NEONATAL ICU	960,458	960,458	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	7,737,458	7,737,458	0	246,400	0	4.00
5.00	54.01	RADIOLOGY - ULTRASOUND	2,160	2,160	0	211,500	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	146,136	138,186	7,950	211,500	53	6.00
7.00	57.00	CT SCAN	4,488	4,488	0	211,500	0	7.00
8.00	65.00	RESPIRATORY THERAPY	-20,750	-20,750	0	211,500	0	8.00
9.00	90.00	CLINIC	85,648	85,648	0	211,500	0	9.00
10.00	91.00	EMERGENCY	2,215,891	2,215,891	0	211,500	0	10.00
200.00			14,282,346	14,274,396	7,950		53	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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.01	NEONATAL ICU	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	5,389	269	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	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			5,389	269	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	13.00	NURSING ADMINISTRATION	0	0	0	3,730		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,147,127		2.00
3.00	31.01	NEONATAL ICU	0	0	0	960,458		3.00
4.00	50.00	OPERATING ROOM	0	0	0	7,737,458		4.00
5.00	54.01	RADIOLOGY - ULTRASOUND	0	0	0	2,160		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	5,389	2,561	140,747		6.00
7.00	57.00	CT SCAN	0	0	0	4,488		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	-20,750		8.00
9.00	90.00	CLINIC	0	0	0	85,648		9.00
10.00	91.00	EMERGENCY	0	0	0	2,215,891		10.00
200.00			0	5,389	2,561	14,276,957		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES		
		RELATED COSTS BLDG & FIXT					
	0	1.00	4.00	5.01	5.02		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	17,072,607	17,072,607				1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	32,722,890	71,504	32,794,394			4.00	
5.01 00550 DATA PROCESSING	11,994,313	111,264	1,020,744	13,126,321		5.01	
5.02 00560 PURCHASING RECEIVING AND STORES	3,321,674	88,769	209,194	0	3,619,637	5.02	
5.03 00570 ADMITTING	2,943,623	117,645	548,565	0	5,252	5.03	
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	6,562,624	371,034	496,516	0	1,126	5.04	
5.05 00590 OTHER A&G	18,821,760	1,205,612	2,336,934	13,126,321	1,797	5.05	
5.06 00592 PATIENT TRANSPORTATION	516,665	0	106,190	0	582	5.06	
7.00 00700 OPERATION OF PLANT	19,019,898	3,624,003	831,889	0	35,547	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	1,309,444	215,809	0	0	43	8.00	
9.00 00900 HOUSEKEEPING	5,094,910	249,830	925,533	0	32,319	9.00	
10.00 01000 DIETARY	2,362,545	228,194	293,819	0	53,368	10.00	
11.00 01100 CAFETERIA	3,426,916	159,535	503,108	0	129	11.00	
13.00 01300 NURSING ADMINISTRATION	5,779,741	76,880	1,000,694	0	25,000	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	2,540,710	433,954	133,719	0	41,702	14.00	
15.00 01500 PHARMACY	5,658,396	229,514	0	0	9,250	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	2,624,777	136,895	468,389	0	532	16.00	
17.00 01700 SOCIAL SERVICE	423,230	19,722	94,803	0	0	17.00	
17.01 01701 STAFF EDUCATION	0	134,958	0	0	0	17.01	
17.02 01702 MEDICAL EDUCATION	10,346	4,528	105	0	121	17.02	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	254,151	0	0	0	0	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	31,168	54,082	0	0	0	22.00	
23.00 02300 PARAMED ED PROGRAM	644,557	40,728	157,840	0	1,034	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	44,406,177	3,792,150	5,737,070	0	350,827	30.00	
31.00 03100 INTENSIVE CARE UNIT	10,967,854	240,495	1,769,672	0	86,977	31.00	
31.01 03101 NEONATAL ICU	1,864,665	27,338	333,373	0	2,234	31.01	
40.00 04000 SUBPROVIDER - I PF	1,006,634	48,089	208,076	0	50	40.00	
41.00 04100 SUBPROVIDER - I RF	2,126,988	378,262	411,315	0	7,601	41.00	
43.00 04300 NURSERY	1,519,180	295,704	280,813	0	11,866	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	8,191,967	722,152	963,156	0	86,243	50.00	
50.01 05001 ENDOSCOPY	1,177,170	0	161,519	0	21,304	50.01	
51.00 05100 RECOVERY ROOM	1,149,786	176,110	218,196	0	3,289	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4,168,593	84,786	712,761	0	12,802	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,631,384	642,390	498,756	0	12,024	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	1,694,884	61,189	285,917	0	9,244	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	2,541,361	163,264	109,992	0	1,743	55.00	
55.01 05501 INFUSION CENTER	47,264	4,359	4,160	0	2,179	55.01	
56.00 05600 RADIOISOTOPE	1,671,915	109,484	127,195	0	66,665	56.00	
57.00 05700 CT SCAN	2,070,266	103,673	267,030	0	27,543	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	815,616	50,910	103,664	0	5,338	58.00	
59.00 05900 CARDIAC CATHETERIZATION	3,372,364	97,256	560,477	0	31,638	59.00	
60.00 06000 LABORATORY	12,195,270	284,735	851,701	0	267,742	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,456,689	4,661	261,985	0	19,663	62.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	3,879,077	94,024	618,965	0	62,759	65.00	
66.00 06600 PHYSICAL THERAPY	1,493,596	148,554	307,627	0	1,331	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,199,029	127,669	247,201	0	952	67.00	
68.00 06800 SPEECH PATHOLOGY	505,222	21,744	102,266	0	736	68.00	
69.00 06900 ELECTROCARDIOLOGY	787,632	0	146,645	0	1,406	69.00	
69.01 06901 CARDIAC REHAB	487,335	0	88,471	0	172	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	1,371,782	0	239,803	0	9,853	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,702,025	0	0	0	1,104,796	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11,677,336	0	0	0	941,532	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	21,476,149	20,122	80,744	0	32,293	73.00	
74.00 07400 RENAL DIALYSIS	2,307,145	53,065	79	0	2,395	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	5,403,209	922,330	614,334	0	7,623	90.00	
91.00 09100 EMERGENCY	12,681,042	327,654	1,662,681	0	181,675	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	2,568,640	0	485,495	0	9,875	101.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	328,752,191	16,576,629	27,589,181	13,126,321	3,592,172	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	157	21,805	0	0	13	190.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
				BLDG & FIXT					
			0	1.00		4.00	5.01	5.02	
191.00	19100	RESEARCH	0	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,385,455	323,392	5,183,983	0	0	27,336	192.00
192.01	19201	OTHER NON-REIMBURSABLE	359,611	41,854	0	0	0	78	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	70,869	108,927	21,230	0	0	38	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers		0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	357,568,283	17,072,607	32,794,394	13,126,321		3,619,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B Part I Date/Time Prepared: 5/27/2022 9:02 am

Table with columns: Cost Center Description, ADMITTING (5.03), CASHIERING/AC COUNTS RECEIVABLE (5.04), Subtotal (5A.04), OTHER A&G (5.05), PATIENT TRANSPORTATION (5.06). Rows include categories like GENERAL SERVICE COST CENTERS, INPATIENT ROUTINE SERVICE COST CENTERS, ANCILLARY SERVICE COST CENTERS, and OUTPATIENT SERVICE COST CENTERS.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	
			5.03	5.04	5A.04	5.05	5.06	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,615,085	7,431,300	357,568,283	35,492,424	692,139	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/27/2022 9:02 am			
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT	26,102,263				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	490,570	2,183,952			8.00
9.00	00900	HOUSEKEEPING	567,905	0	7,565,036		9.00
10.00	01000	DIETARY	518,724	0	156,692	3,937,099	10.00
11.00	01100	CAFETERIA	362,650	0	109,547	0	5,012,565
13.00	01300	NURSING ADMINISTRATION	174,761	0	52,790	0	147,479
14.00	01400	CENTRAL SERVICES & SUPPLY	986,451	2,935	297,979	0	65,668
15.00	01500	PHARMACY	521,724	0	157,598	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	311,185	0	94,000	0	187,129
17.00	01700	SOCIAL SERVICE	44,832	0	13,543	0	0
17.01	01701	STAFF EDUCATION	306,781	0	92,670	0	0
17.02	01702	MEDICAL EDUCATION	10,293	0	3,109	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	122,938	0	37,136	0	0
23.00	02300	PARAMED ED PROGRAM	92,582	0	27,966	0	47,672
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,620,180	980,706	2,603,920	3,198,459	1,555,236
31.00	03100	INTENSIVE CARE UNIT	546,686	153,184	165,139	158,050	317,663
31.01	03101	NEONATAL ICU	62,143	0	18,772	0	72,716
40.00	04000	SUBPROVIDER - IPF	109,315	0	33,021	54,044	52,907
41.00	04100	SUBPROVIDER - IRF	859,852	72,727	259,738	186,890	107,416
43.00	04300	NURSERY	672,183	25,913	203,048	0	58,353
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,641,571	250,031	495,873	0	269,851
50.01	05001	ENDOSCOPY	0	34,693	0	0	40,539
51.00	05100	RECOVERY ROOM	400,327	18,501	120,928	1,647	43,377
52.00	05200	DELIVERY ROOM & LABOR ROOM	192,733	48,542	58,219	83,342	177,494
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,460,260	42,999	441,104	0	169,335
54.01	05401	RADIOLOGY - ULTRASOUND	139,093	20,263	42,016	0	71,251
55.00	05500	RADIOLOGY-THERAPEUTIC	371,127	11,475	112,107	0	26,741
55.01	05501	INFUSION CENTER	9,908	0	2,993	0	1,020
56.00	05600	RADIOISOTOPE	248,876	13,589	75,179	0	28,354
57.00	05700	CT SCAN	235,666	27,522	71,188	0	71,850
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	115,728	9,738	34,958	0	31,466
59.00	05900	CARDIAC CATHETERIZATION	221,080	50,783	66,782	0	115,178
60.00	06000	LABORATORY	647,249	0	195,516	0	257,459
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,596	0	3,201	0	127,484
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	213,731	0	64,562	0	137,520
66.00	06600	PHYSICAL THERAPY	337,688	0	102,006	0	72,531
67.00	06700	OCCUPATIONAL THERAPY	290,214	0	87,665	0	57,659
68.00	06800	SPEECH PATHOLOGY	49,428	0	14,931	0	21,867
69.00	06900	ELECTROCARDIOLOGY	0	3,516	0	0	51,281
69.01	06901	CARDIAC REHAB	0	603	0	0	24,152
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,847	0	0	58,828
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	45,741	0	13,817	0	17,581
74.00	07400	RENAL DIALYSIS	120,626	14,512	36,438	0	18
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,096,610	56,387	633,328	0	146,520
91.00	09100	EMERGENCY	744,813	334,486	224,987	254,667	380,970
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,974,820	2,183,952	7,224,466	3,937,099	5,012,565
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,566	0	14,973	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	735,125	0	222,061	0	0
192.01	19201	OTHER NON-REIMBURSABLE	95,142	0	28,740	0	0
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	247,610	0	74,796	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	26,102,263	2,183,952	7,565,036	3,937,099	5,012,565	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part I Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	8,015,769					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,850,254				14.00
15.00	01500	PHARMACY	0	0	7,226,343			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,178,915		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	655,390	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	122,259	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,988,554	0	0	316,335	541,939	30.00
31.00	03100	INTENSIVE CARE UNIT	814,678	0	0	69,681	0	31.00
31.01	03101	NEONATAL ICU	186,486	0	0	18,699	0	31.01
40.00	04000	SUBPROVIDER - I/PF	135,686	0	0	6,771	0	40.00
41.00	04100	SUBPROVIDER - I/RF	275,479	0	0	13,163	86,260	41.00
43.00	04300	NURSERY	149,653	0	0	5,886	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	692,061	0	0	499,245	0	50.00
50.01	05001	ENDOSCOPY	103,968	0	0	36,927	0	50.01
51.00	05100	RECOVERY ROOM	111,244	0	0	35,487	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	455,201	0	0	13,058	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	120,542	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	66,918	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	66,912	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	384	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	47,390	0	56.00
57.00	05700	CT SCAN	0	0	0	397,517	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	92,209	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	208,168	0	59.00
60.00	06000	LABORATORY	0	0	445,161	659,456	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	35,972	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	126,672	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	23,125	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,854	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,532	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	75,915	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	3,234	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	96,162	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,618,598	0	162,742	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,231,656	0	104,464	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,703,221	478,643	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	27,719	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,465	0	0	70,859	0	90.00
91.00	09100	EMERGENCY	977,035	0	0	261,642	27,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	8,133	11,632	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,015,769	4,850,254	7,156,515	4,178,915	655,390	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	69,828	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	8,015,769	4,850,254	7,226,343	4,178,915	655,390	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

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Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.01	17.02		
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00570 ADMITTING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590 OTHER A&G						5.05
5.06 00592 PATIENT TRANSPORTATION						5.06
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						17.00
17.01 01701 STAFF EDUCATION	549,281					17.01
17.02 01702 MEDICAL EDUCATION	59	30,225				17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	282,158			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		254,718		22.00
23.00 02300 PARAMED PROGRAM	190	0			1,227,853	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	223,776	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	38,313	0	0	0	0	31.00
31.01 03101 NEONATAL ICU	7,645	0	0	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	2,160	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	26,673	0	0	0	0	41.00
43.00 04300 NURSERY	11,414	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	30,080	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	14,453	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	1,401	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	29,997	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	11,550	0	0	0	0	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	6,713	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	1,549	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	12	0	0	0	0	56.00
57.00 05700 CT SCAN	10,612	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	19,468	0	0	0	0	59.00
60.00 06000 LABORATORY	1,359	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	510	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	4,351	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	878	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	368	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	410	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	6,962	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	47	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	4,084	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,543	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,424	0	0	0	0	90.00
91.00 09100 EMERGENCY	80,507	30,225	282,158	254,718	1,227,853	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2,297	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	540,805	30,225	282,158	254,718	1,227,853	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	8,203	0	0	0	0	192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Period:
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Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED ED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.01	17.02		
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	273	0	0	0	0	192.02
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	549,281	30,225	282,158	254,718	1,227,853	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	83,469,209	0	83,469,209	30.00
31.00	03100	16,976,791	0	16,976,791	31.00
31.01	03101	2,894,417	0	2,894,417	31.01
40.00	04000	1,815,787	0	1,815,787	40.00
41.00	04100	5,176,818	0	5,176,818	41.00
43.00	04300	3,483,536	0	3,483,536	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	16,405,073	0	16,405,073	50.00
50.01	05001	1,867,097	0	1,867,097	50.01
51.00	05100	2,554,938	0	2,554,938	51.00
52.00	05200	6,633,702	0	6,633,702	52.00
53.00	05300	0	0	0	53.00
54.00	05400	7,952,671	0	7,952,671	54.00
54.01	05401	2,902,450	0	2,902,450	54.01
55.00	05500	3,916,620	0	3,916,620	55.00
55.01	05501	79,781	0	79,781	55.01
56.00	05600	2,787,732	0	2,787,732	56.00
57.00	05700	4,870,909	0	4,870,909	57.00
58.00	05800	1,687,734	0	1,687,734	58.00
59.00	05900	5,825,663	0	5,825,663	59.00
60.00	06000	19,241,253	0	19,241,253	60.00
62.00	06200	2,218,385	0	2,218,385	62.00
64.00	06400	0	0	0	64.00
65.00	06500	6,086,490	0	6,086,490	65.00
66.00	06600	2,770,198	0	2,770,198	66.00
67.00	06700	2,250,612	0	2,250,612	67.00
68.00	06800	819,592	0	819,592	68.00
69.00	06900	1,402,745	0	1,402,745	69.00
69.01	06901	676,974	0	676,974	69.01
70.00	07000	2,260,413	0	2,260,413	70.00
71.00	07100	19,697,372	0	19,697,372	71.00
72.00	07200	16,652,092	0	16,652,092	72.00
73.00	07300	32,655,600	0	32,655,600	73.00
74.00	07400	2,903,716	0	2,903,716	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	10,929,976	0	10,929,976	90.00
91.00	09100	22,346,221	-536,876	21,809,345	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	3,457,854	0	3,457,854	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		317,670,421	-536,876	317,133,545	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	88,936	0	88,936	190.00
191.00	19100	0	0	0	191.00
192.00	19200	38,693,351	0	38,693,351	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.01	19201	OTHER NON-REIMBURSABLE	569,675	0	569,675	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	545,900	0	545,900	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	357,568,283	-536,876	357,031,407	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING
			BLDG & FIXT			
	0	1.00	2A	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	71,504	71,504	4.00
5.01	00550	DATA PROCESSING	0	111,264	111,264	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	88,769	88,769	5.02
5.03	00570	ADMINISTRATIVE	0	117,645	117,645	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	371,034	371,034	5.04
5.05	00590	OTHER A&G	0	1,205,612	1,205,612	5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	0	5.06
7.00	00700	OPERATION OF PLANT	0	3,624,003	3,624,003	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	215,809	215,809	8.00
9.00	00900	HOUSEKEEPING	0	249,830	249,830	9.00
10.00	01000	DIETARY	0	228,194	228,194	10.00
11.00	01100	CAFETERIA	0	159,535	159,535	11.00
13.00	01300	NURSING ADMINISTRATION	0	76,880	76,880	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	433,954	433,954	14.00
15.00	01500	PHARMACY	0	229,514	229,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	136,895	136,895	16.00
17.00	01700	SOCIAL SERVICE	0	19,722	19,722	17.00
17.01	01701	STAFF EDUCATION	0	134,958	134,958	17.01
17.02	01702	MEDICAL EDUCATION	0	4,528	4,528	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	54,082	54,082	22.00
23.00	02300	PARAMED PROGRAM	0	40,728	40,728	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,792,150	3,792,150	30.00
31.00	03100	INTENSIVE CARE UNIT	0	240,495	240,495	31.00
31.01	03101	NEONATAL ICU	0	27,338	27,338	31.01
40.00	04000	SUBPROVIDER - IPF	0	48,089	48,089	40.00
41.00	04100	SUBPROVIDER - IRF	0	378,262	378,262	41.00
43.00	04300	NURSERY	0	295,704	295,704	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	722,152	722,152	50.00
50.01	05001	ENDOSCOPY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	176,110	176,110	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	84,786	84,786	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	642,390	642,390	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	61,189	61,189	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	163,264	163,264	55.00
55.01	05501	INFUSION CENTER	0	4,359	4,359	55.01
56.00	05600	RADIOISOTOPE	0	109,484	109,484	56.00
57.00	05700	CT SCAN	0	103,673	103,673	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	50,910	50,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	97,256	97,256	59.00
60.00	06000	LABORATORY	0	284,735	284,735	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,661	4,661	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	94,024	94,024	65.00
66.00	06600	PHYSICAL THERAPY	0	148,554	148,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	127,669	127,669	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,744	21,744	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,122	20,122	73.00
74.00	07400	RENAL DIALYSIS	0	53,065	53,065	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	922,330	922,330	90.00
91.00	09100	EMERGENCY	0	327,654	327,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16,576,629	16,576,629	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,805	21,805	190.00
191.00	19100	RESEARCH	0	0	0	191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		0	1.00				
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	323,392	323,392	11,294	0	192.00	
192.01 19201 OTHER NON-REIMBURSABLE	0	41,854	41,854	0	0	192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	108,927	108,927	46	0	192.02	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
200.00 Cross Foot Adjustments			0			200.00	
201.00 Negative Cost Centers			0		0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	17,072,607	17,072,607	71,504	113,488	202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am		
Cost Center Description		PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION		
		5.02	5.03	5.04	5.05	5.06		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES	89,225				5.02	
5.03	00570	ADMITTING	130	118,970			5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	28	0	372,144		5.04	
5.05	00590	OTHER A&G	44	0	0	1,324,235	5.05	
5.06	00592	PATIENT TRANSPORTATION	14	0	0	2,564	5.06	
7.00	00700	OPERATION OF PLANT	876	0	0	96,679	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	0	6,272	8.00	
9.00	00900	HOUSEKEEPING	797	0	0	25,916	9.00	
10.00	01000	DIETARY	1,316	0	0	12,081	10.00	
11.00	01100	CAFETERIA	3	0	0	16,817	11.00	
13.00	01300	NURSING ADMINISTRATION	616	0	0	28,300	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,028	0	0	12,953	14.00	
15.00	01500	PHARMACY	228	0	0	24,249	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	13	0	0	13,284	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	2,211	17.00	
17.01	01701	STAFF EDUCATION	0	0	0	555	17.01	
17.02	01702	MEDICAL EDUCATION	3	0	0	62	17.02	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,045	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	351	22.00	
23.00	02300	PARAMED PROGRAM	26	0	0	3,471	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,650	9,011	28,212	226,523	989	30.00
31.00	03100	INTENSIVE CARE UNIT	2,145	1,985	6,214	54,481	17	31.00
31.01	03101	NEONATAL ICU	55	533	1,668	9,363	0	31.01
40.00	04000	SUBPROVIDER - I/PF	1	193	604	5,266	0	40.00
41.00	04100	SUBPROVIDER - I/RF	187	375	1,174	12,167	15	41.00
43.00	04300	NURSERY	293	168	525	8,730	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,126	14,221	44,524	46,396	0	50.00
50.01	05001	ENDOSCOPY	525	1,052	3,293	5,994	74	50.01
51.00	05100	RECOVERY ROOM	81	1,011	3,165	6,748	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316	372	1,165	20,615	37	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296	3,434	10,750	20,984	168	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	228	1,906	5,968	9,162	335	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	43	1,906	5,967	12,308	15	55.00
55.01	05501	INFUSION CENTER	54	11	34	243	0	55.01
56.00	05600	RADIOISOTOPE	1,644	1,350	4,226	8,637	172	56.00
57.00	05700	CT SCAN	679	11,323	35,452	14,471	607	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	132	2,626	8,223	5,013	203	58.00
59.00	05900	CARDIAC CATHETERIZATION	780	5,930	18,565	18,964	98	59.00
60.00	06000	LABORATORY	6,601	18,717	58,271	63,095	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	485	1,025	3,208	7,558	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,547	3,608	11,297	20,517	1	65.00
66.00	06600	PHYSICAL THERAPY	33	659	2,062	8,274	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23	480	1,503	6,659	0	67.00
68.00	06800	SPEECH PATHOLOGY	18	243	761	2,683	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35	2,162	6,770	4,673	14	69.00
69.01	06901	CARDIAC REHAB	4	92	288	2,404	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	243	2,739	8,576	7,712	33	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,221	4,636	14,514	62,654	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,215	2,976	9,316	53,024	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	796	13,634	42,687	94,059	0	73.00
74.00	07400	RENAL DIALYSIS	59	790	2,472	10,017	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	188	2,018	6,319	29,338	1	90.00
91.00	09100	EMERGENCY	4,479	7,453	23,334	63,919	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	243	331	1,037	12,726	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,548	118,970	372,144	1,182,187	2,809	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	90	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	674	0	0	139,480	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	2	0	0	1,651	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	1	0	0	827	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	OTHER A&G	PATIENT TRANSPORTATION	
			5.02	5.03	5.04	5.05	5.06	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,225	118,970	372,144	1,324,235	2,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER A&G					5.05
5.06	00592	PATIENT TRANSPORTATION					5.06
7.00	00700	OPERATION OF PLANT	3,723,370				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,978	292,060			8.00
9.00	00900	HOUSEKEEPING	81,009	0	359,568		9.00
10.00	01000	DIETARY	73,994	0	7,448	323,673	10.00
11.00	01100	CAFETERIA	51,730	0	5,207	0	234,388
13.00	01300	NURSING ADMINISTRATION	24,929	0	2,509	0	6,896
14.00	01400	CENTRAL SERVICES & SUPPLY	140,713	392	14,163	0	3,071
15.00	01500	PHARMACY	74,422	0	7,491	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	44,389	0	4,468	0	8,750
17.00	01700	SOCIAL SERVICE	6,395	0	644	0	0
17.01	01701	STAFF EDUCATION	43,761	0	4,405	0	0
17.02	01702	MEDICAL EDUCATION	1,468	0	148	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	17,537	0	1,765	0	0
23.00	02300	PARAMED ED PROGRAM	13,206	0	1,329	0	2,229
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,229,630	131,150	123,762	262,950	72,722
31.00	03100	INTENSIVE CARE UNIT	77,982	20,485	7,849	12,993	14,854
31.01	03101	NEONATAL ICU	8,864	0	892	0	3,400
40.00	04000	SUBPROVIDER - I/PF	15,593	0	1,570	4,443	2,474
41.00	04100	SUBPROVIDER - I/RF	122,654	9,726	12,345	15,364	5,023
43.00	04300	NURSERY	95,884	3,465	9,651	0	2,729
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	234,163	33,437	23,569	0	12,618
50.01	05001	ENDOSCOPY	0	4,639	0	0	1,896
51.00	05100	RECOVERY ROOM	57,105	2,474	5,748	135	2,028
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,492	6,492	2,767	6,852	8,300
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	208,299	5,750	20,966	0	7,918
54.01	05401	RADIOLOGY - ULTRASOUND	19,841	2,710	1,997	0	3,332
55.00	05500	RADIOLOGY-THERAPEUTIC	52,940	1,535	5,328	0	1,250
55.01	05501	INFUSION CENTER	1,413	0	142	0	48
56.00	05600	RADIOISOTOPE	35,501	1,817	3,573	0	1,326
57.00	05700	CT SCAN	33,617	3,680	3,384	0	3,360
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,508	1,302	1,662	0	1,471
59.00	05900	CARDIAC CATHETERIZATION	31,536	6,791	3,174	0	5,386
60.00	06000	LABORATORY	92,327	0	9,293	0	12,039
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,511	0	152	0	5,961
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	30,488	0	3,069	0	6,430
66.00	06600	PHYSICAL THERAPY	48,170	0	4,848	0	3,392
67.00	06700	OCCUPATIONAL THERAPY	41,398	0	4,167	0	2,696
68.00	06800	SPEECH PATHOLOGY	7,051	0	710	0	1,023
69.00	06900	ELECTROCARDIOLOGY	0	470	0	0	2,398
69.01	06901	CARDIAC REHAB	0	81	0	0	1,129
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,451	0	0	2,751
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,525	0	657	0	822
74.00	07400	RENAL DIALYSIS	17,207	1,941	1,732	0	1
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	299,072	7,541	30,102	0	6,851
91.00	09100	EMERGENCY	106,244	44,731	10,694	20,936	17,814
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,562,546	292,060	343,380	323,673	234,388
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,070	0	712	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	104,862	0	10,555	0	0
192.01	19201	OTHER NON-REIMBURSABLE	13,572	0	1,366	0	0
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	35,320	0	3,555	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002			Period: From 01/01/2021 To 12/31/2021		Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,723,370	292,060	359,568	323,673	234,388		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am			
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
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	142,310					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	606,565				14.00
15.00	01500	PHARMACY	0	0	335,904			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	208,819		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	29,179	17.00
17.01	01701	STAFF EDUCATION	0	0	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	0	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	2,171	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,809	0	0	15,768	24,128	30.00
31.00	03100	INTENSIVE CARE UNIT	14,464	0	0	3,473	0	31.00
31.01	03101	NEONATAL ICU	3,311	0	0	932	0	31.01
40.00	04000	SUBPROVIDER - IPF	2,409	0	0	338	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,891	0	0	656	3,840	41.00
43.00	04300	NURSERY	2,657	0	0	293	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,287	0	0	24,886	0	50.00
50.01	05001	ENDOSCOPY	1,846	0	0	1,841	0	50.01
51.00	05100	RECOVERY ROOM	1,975	0	0	1,769	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,082	0	0	651	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,009	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	3,336	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,335	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	19	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	2,362	0	56.00
57.00	05700	CT SCAN	0	0	0	19,815	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,596	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	10,377	0	59.00
60.00	06000	LABORATORY	0	0	20,693	33,386	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,793	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,314	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,153	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	840	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	425	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,784	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	161	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,793	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	327,477	0	8,112	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	279,088	0	5,207	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	311,587	23,859	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,382	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	62	0	0	3,532	0	90.00
91.00	09100	EMERGENCY	17,346	0	0	13,042	1,211	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	378	580	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	142,310	606,565	332,658	208,819	29,179	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,246	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	142,310	606,565	335,904	208,819	29,179	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS		PARAMED PROGRAM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
	17.01	17.02	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER A&G					5.05
5.06 00592	PATIENT TRANSPORTATION					5.06
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					17.00
17.01 01701	STAFF EDUCATION	183,679				17.01
17.02 01702	MEDICAL EDUCATION	20	6,229			17.02
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,045		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	73,735	22.00
23.00 02300	PARAMED PROGRAM	64	0	0	0	23.00
						63,568
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	74,829	0			30.00
31.00 03100	INTENSIVE CARE UNIT	12,812	0			31.00
31.01 03101	NEONATAL ICU	2,556	0			31.01
40.00 04000	SUBPROVIDER - I PF	722	0			40.00
41.00 04100	SUBPROVIDER - I RF	8,920	0			41.00
43.00 04300	NURSERY	3,817	0			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,059	0			50.00
50.01 05001	ENDOSCOPY	4,833	0			50.01
51.00 05100	RECOVERY ROOM	468	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,031	0			52.00
53.00 05300	ANESTHESIOLOGY	0	0			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,862	0			54.00
54.01 05401	RADIOLOGY - ULTRASOUND	2,245	0			54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	518	0			55.00
55.01 05501	INFUSION CENTER	0	0			55.01
56.00 05600	RADIOISOTOPE	4	0			56.00
57.00 05700	CT SCAN	3,549	0			57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00 05900	CARDIAC CATHETERIZATION	6,510	0			59.00
60.00 06000	LABORATORY	455	0			60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	171	0			62.00
64.00 06400	INTRAVENOUS THERAPY	0	0			64.00
65.00 06500	RESPIRATORY THERAPY	1,455	0			65.00
66.00 06600	PHYSICAL THERAPY	294	0			66.00
67.00 06700	OCCUPATIONAL THERAPY	123	0			67.00
68.00 06800	SPEECH PATHOLOGY	137	0			68.00
69.00 06900	ELECTROCARDIOLOGY	2,328	0			69.00
69.01 06901	CARDIAC REHAB	16	0			69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	1,366	0			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	516	0			73.00
74.00 07400	RENAL DIALYSIS	0	0			74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	476	0			90.00
91.00 09100	EMERGENCY	26,921	6,229			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	768	0			101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	180,845	6,229	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
191.00 19100	RESEARCH	0	0			191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,743	0			192.00
192.01 19201	OTHER NON-REIMBURSABLE	0	0			192.01

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am				
Cost Center Description		STAFF EDUCATION 17.01	MEDICAL EDUCATION 17.02	INTERNS & RESIDENTS		PARAMED ED PROGRAM 23.00		
				SERVICES-SALA RY & FRINGES 21.00	SERVICES-OTHE R PRGM COSTS 22.00			
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	91	0			192.02	
193.00	19300	NONPAID WORKERS	0	0			193.00	
200.00		Cross Foot Adjustments			1,045	73,735	63,568	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	183,679	6,229	1,045	73,735	63,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00570				5.03
5.04	00580				5.04
5.05	00590				5.05
5.06	00592				5.06
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
17.02	01702				17.02
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	6,083,843	0	6,083,843	30.00
31.00	03100	474,104	0	474,104	31.00
31.01	03101	59,638	0	59,638	31.01
40.00	04000	82,155	0	82,155	40.00
41.00	04100	576,495	0	576,495	41.00
43.00	04300	424,528	0	424,528	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,182,536	0	1,182,536	50.00
50.01	05001	26,345	0	26,345	50.01
51.00	05100	259,292	0	259,292	51.00
52.00	05200	179,511	0	179,511	52.00
53.00	05300	0	0	0	53.00
54.00	05400	931,913	0	931,913	54.00
54.01	05401	112,872	0	112,872	54.01
55.00	05500	248,649	0	248,649	55.00
55.01	05501	6,332	0	6,332	55.01
56.00	05600	170,373	0	170,373	56.00
57.00	05700	234,192	0	234,192	57.00
58.00	05800	92,872	0	92,872	58.00
59.00	05900	206,588	0	206,588	59.00
60.00	06000	601,467	0	601,467	60.00
62.00	06200	27,096	0	27,096	62.00
64.00	06400	0	0	0	64.00
65.00	06500	180,098	0	180,098	65.00
66.00	06600	218,109	0	218,109	66.00
67.00	06700	186,097	0	186,097	67.00
68.00	06800	35,018	0	35,018	68.00
69.00	06900	22,953	0	22,953	69.00
69.01	06901	4,368	0	4,368	69.01
70.00	07000	30,186	0	30,186	70.00
71.00	07100	444,614	0	444,614	71.00
72.00	07200	372,826	0	372,826	72.00
73.00	07300	515,440	0	515,440	73.00
74.00	07400	88,666	0	88,666	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	1,309,168	0	1,309,168	90.00
91.00	09100	695,659	0	695,659	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	17,121	0	17,121	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		16,101,124	0	16,101,124	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	29,677	0	29,677	190.00
191.00	19100	0	0	0	191.00
192.00	19200	596,246	0	596,246	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.01	19201	OTHER NON-REIMBURSABLE	58,445	0	58,445	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	148,767	0	148,767	192.02
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	138,348	0	138,348	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,072,607	0	17,072,607	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,410,133				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,906	146,403,953			4.00
5.01 00550	DATA PROCESSING	9,190	4,556,912	100		5.01
5.02 00560	PURCHASING RECEIVING AND STORES	7,332	933,907	0	44,892,295	5.02
5.03 00570	ADMITTING	9,717	2,448,960	0	65,141	1,417,261,476
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	30,646	2,216,600	0	13,960	0
5.05 00590	OTHER A&G	99,579	10,432,786	100	22,287	0
5.06 00592	PATIENT TRANSPORTATION	0	474,063	0	7,220	0
7.00 00700	OPERATION OF PLANT	299,329	3,713,808	0	440,870	0
8.00 00800	LAUNDRY & LINEN SERVICE	17,825	0	0	534	0
9.00 00900	HOUSEKEEPING	20,635	4,131,863	0	400,832	0
10.00 01000	DIETARY	18,848	1,311,699	0	661,894	0
11.00 01100	CAFETERIA	13,177	2,246,027	0	1,597	0
13.00 01300	NURSING ADMINISTRATION	6,350	4,467,402	0	310,063	0
14.00 01400	CENTRAL SERVICES & SUPPLY	35,843	596,961	0	517,214	0
15.00 01500	PHARMACY	18,957	0	0	114,725	0
16.00 01600	MEDICAL RECORDS & LIBRARY	11,307	2,091,030	0	6,596	0
17.00 01700	SOCIAL SERVICE	1,629	423,230	0	0	0
17.01 01701	STAFF EDUCATION	11,147	0	0	0	0
17.02 01702	MEDICAL EDUCATION	374	469	0	1,496	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,467	0	0	0	0
23.00 02300	PARAMED ED PROGRAM	3,364	704,647	0	12,828	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	313,217	25,611,802	0	4,351,130	107,268,496
31.00 03100	INTENSIVE CARE UNIT	19,864	7,900,355	0	1,078,737	23,628,573
31.01 03101	NEONATAL ICU	2,258	1,488,278	0	27,712	6,340,767
40.00 04000	SUBPROVIDER - I/PF	3,972	928,913	0	624	2,296,180
41.00 04100	SUBPROVIDER - I/RF	31,243	1,836,234	0	94,271	4,463,400
43.00 04300	NURSERY	24,424	1,253,634	0	147,169	1,996,068
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	59,647	4,299,823	0	1,069,632	169,292,906
50.01 05001	ENDOSCOPY	0	721,071	0	264,226	12,521,947
51.00 05100	RECOVERY ROOM	14,546	974,092	0	40,796	12,033,588
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,003	3,181,984	0	158,774	4,428,022
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	53,059	2,226,600	0	149,129	40,875,566
54.01 05401	RADIOLOGY - ULTRASOUND	5,054	1,276,422	0	114,643	22,691,762
55.00 05500	RADIOLOGY-THERAPEUTIC	13,485	491,036	0	21,620	22,689,787
55.01 05501	INFUSION CENTER	360	18,571	0	27,022	130,187
56.00 05600	RADIOISOTOPE	9,043	567,839	0	826,812	16,069,979
57.00 05700	CT SCAN	8,563	1,192,103	0	341,599	134,797,158
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,205	462,789	0	66,201	31,267,753
59.00 05900	CARDIAC CATHETERIZATION	8,033	2,502,141	0	392,384	70,589,396
60.00 06000	LABORATORY	23,518	3,802,254	0	3,320,669	223,819,693
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1,169,580	0	243,871	12,197,992
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	7,766	2,763,247	0	778,363	42,954,297
66.00 06600	PHYSICAL THERAPY	12,270	1,373,339	0	16,508	7,841,511
67.00 06700	OCCUPATIONAL THERAPY	10,545	1,103,581	0	11,809	5,715,234
68.00 06800	SPEECH PATHOLOGY	1,796	456,545	0	9,124	2,893,110
69.00 06900	ELECTROCARDIOLOGY	0	654,669	0	17,440	25,742,675
69.01 06901	CARDIAC REHAB	0	394,960	0	2,136	1,096,565
70.00 07000	ELECTROENCEPHALOGRAPHY	0	1,070,555	0	122,196	32,608,358
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,702,025	55,185,539
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,677,336	35,423,662
73.00 07300	DRUGS CHARGED TO PATIENTS	1,662	360,465	0	400,515	162,306,726
74.00 07400	RENAL DIALYSIS	4,383	352	0	29,699	9,399,418
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	76,181	2,742,574	0	94,540	24,028,280
91.00 09100	EMERGENCY	27,063	7,422,718	0	2,253,225	88,722,447
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	2,167,399	0	122,473	3,944,434
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,369,167	123,166,289	100	44,551,667	1,417,261,476
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,801	0	0	157	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUIREMENTS)	ADMITTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)						
			1.00	4.00	5.01	5.02	5.03		
191.00	19100	RESEARCH	0	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,711	23,142,886	0	0	339,039	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	3,457	0	0	0	965	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	8,997	94,778	0	0	467	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers							201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	17,072,607	32,794,394	13,126,321	3,619,637	3,615,085		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.107090	0.223999	131,263.210000	0.080629	0.002551		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		71,504	113,488	89,225	118,970		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000488	1,134.880000	0.001988	0.000084		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)							206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1		Date/Time Prepared: 5/27/2022 9:02 am
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
	5.04	5A.05	5.05	5.06	7.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMITTING				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,417,261,476			5.04
5.05	00590	OTHER A&G	0	-35,492,424		5.05
5.06	00592	PATIENT TRANSPORTATION	0	0	32,181	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	948,434
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	17,825
9.00	00900	HOUSEKEEPING	0	0	0	20,635
10.00	01000	DIETARY	0	0	0	18,848
11.00	01100	CAFETERIA	0	0	0	13,177
13.00	01300	NURSING ADMINISTRATION	0	0	0	6,350
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	35,843
15.00	01500	PHARMACY	0	0	0	18,957
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	11,307
17.00	01700	SOCIAL SERVICE	0	0	0	1,629
17.01	01701	STAFF EDUCATION	0	0	0	11,147
17.02	01702	MEDICAL EDUCATION	0	0	0	374
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	4,467
23.00	02300	PARAMED ED PROGRAM	0	0	0	3,364
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,268,496	0	11,318	313,217
31.00	03100	INTENSIVE CARE UNIT	23,628,573	0	195	19,864
31.01	03101	NEONATAL ICU	6,340,767	0	0	2,258
40.00	04000	SUBPROVIDER - IPF	2,296,180	0	0	3,972
41.00	04100	SUBPROVIDER - IRF	4,463,400	0	167	31,243
43.00	04300	NURSERY	1,996,068	0	0	24,424
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,292,906	0	0	59,647
50.01	05001	ENDOSCOPY	12,521,947	0	851	0
51.00	05100	RECOVERY ROOM	12,033,588	0	0	14,546
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,428,022	0	427	7,003
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,875,566	0	1,924	53,059
54.01	05401	RADIOLOGY - ULTRASOUND	22,691,762	0	3,839	5,054
55.00	05500	RADIOLOGY-THERAPEUTIC	22,689,787	0	170	13,485
55.01	05501	INFUSION CENTER	130,187	0	0	360
56.00	05600	RADIOISOTOPE	16,069,979	0	1,969	9,043
57.00	05700	CT SCAN	134,797,158	0	6,957	8,563
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	31,267,753	0	1,219,229	4,205
59.00	05900	CARDIAC CATHETERIZATION	70,589,396	0	1,119	8,033
60.00	06000	LABORATORY	223,819,693	0	0	23,518
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,197,992	0	0	385
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	42,954,297	0	9	7,766
66.00	06600	PHYSICAL THERAPY	7,841,511	0	0	12,270
67.00	06700	OCCUPATIONAL THERAPY	5,715,234	0	0	10,545
68.00	06800	SPEECH PATHOLOGY	2,893,110	0	0	1,796
69.00	06900	ELECTROCARDIOLOGY	25,742,675	0	164	0
69.01	06901	CARDIAC REHAB	1,096,565	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	32,608,358	0	382	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,185,539	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,423,662	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	162,306,726	0	0	1,662
74.00	07400	RENAL DIALYSIS	9,399,418	0	1	4,383
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,028,280	0	17	76,181
91.00	09100	EMERGENCY	88,722,447	0	345	27,063
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,944,434	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,417,261,476	-35,492,424	287,531,111	32,181
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,801
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	26,711

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	
			5.04	5A.05	5.05	5.06	7.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	401,543	0	3,457	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	201,064	0	8,997	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,431,300		35,492,424	692,139	26,102,263	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005243		0.110199	21.507691	27.521433	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	372,144		1,324,235	2,809	3,723,370	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000263		0.004112	0.087288	3.925808	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet B-1	
Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER A&G						5.05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,734,752					8.00
9.00	00900	HOUSEKEEPING	0	909,974				9.00
10.00	01000	DIETARY	0	18,848	274,937			10.00
11.00	01100	CAFETERIA	0	13,177	0	2,259,516		11.00
13.00	01300	NURSING ADMINISTRATION	0	6,350	0	66,479	1,408,903	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	35,843	0	29,601	0	14.00
15.00	01500	PHARMACY	0	18,957	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,307	0	84,352	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,629	0	0	0	17.00
17.01	01701	STAFF EDUCATION	0	11,147	0	0	0	17.01
17.02	01702	MEDICAL EDUCATION	0	374	0	0	0	17.02
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,467	0	0	0	22.00
23.00	02300	PARAMED PROGRAM	0	3,364	0	21,489	21,489	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	778,993	313,217	223,356	701,054	701,054	30.00
31.00	03100	INTENSIVE CARE UNIT	121,677	19,864	11,037	143,193	143,193	31.00
31.01	03101	NEONATAL ICU	0	2,258	0	32,778	32,778	31.01
40.00	04000	SUBPROVIDER - IPF	0	3,972	3,774	23,849	23,849	40.00
41.00	04100	SUBPROVIDER - IRF	57,768	31,243	13,051	48,420	48,420	41.00
43.00	04300	NURSERY	20,583	24,424	0	26,304	26,304	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	198,604	59,647	0	121,641	121,641	50.00
50.01	05001	ENDOSCOPY	27,557	0	0	18,274	18,274	50.01
51.00	05100	RECOVERY ROOM	14,696	14,546	115	19,553	19,553	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,558	7,003	5,820	80,009	80,009	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,155	53,059	0	76,331	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	16,095	5,054	0	32,118	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	9,115	13,485	0	12,054	0	55.00
55.01	05501	INFUSION CENTER	0	360	0	460	0	55.01
56.00	05600	RADIO SOTOP	10,794	9,043	0	12,781	0	56.00
57.00	05700	CT SCAN	21,861	8,563	0	32,388	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,735	4,205	0	14,184	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,338	8,033	0	51,919	0	59.00
60.00	06000	LABORATORY	0	23,518	0	116,055	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	385	0	57,466	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,766	0	61,990	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,270	0	32,695	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,545	0	25,991	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,796	0	9,857	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,793	0	0	23,116	0	69.00
69.01	06901	CARDIAC REHAB	479	0	0	10,887	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	8,616	0	0	26,518	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,662	0	7,925	0	73.00
74.00	07400	RENAL DIALYSIS	11,527	4,383	0	8	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	44,789	76,181	0	66,047	609	90.00
91.00	09100	EMERGENCY	265,688	27,063	17,784	171,730	171,730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,734,752	869,008	274,937	2,259,516	1,408,903	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,801	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,711	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	3,457	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	8,997	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,183,952	7,565,036	3,937,099	5,012,565	8,015,769	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.258942	8.313464	14.320004	2.218424	5.689369	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	292,060	359,568	323,673	234,388	142,310	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.168358	0.395141	1.177262	0.103734	0.101008	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepared: 5/27/2022 9:02 am		
Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
	14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER A&G					5.05
5.06 00592	PATIENT TRANSPORTATION					5.06
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	25,379,361				14.00
15.00 01500	PHARMACY	0	21,942,137			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	1,417,261,476		16.00
17.00 01700	SOCIAL SERVICE	0	0	0	699	17.00
17.01 01701	STAFF EDUCATION	0	0	0	0	92,544
17.02 01702	MEDICAL EDUCATION	0	0	0	0	10
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED PROGRAM	0	0	0	0	32
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	107,268,496	578	37,702
31.00 03100	INTENSIVE CARE UNIT	0	0	23,628,573	0	6,455
31.01 03101	NEONATAL ICU	0	0	6,340,767	0	1,288
40.00 04000	SUBPROVIDER - IPF	0	0	2,296,180	0	364
41.00 04100	SUBPROVIDER - IRF	0	0	4,463,400	92	4,494
43.00 04300	NURSERY	0	0	1,996,068	0	1,923
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	169,292,906	0	5,068
50.01 05001	ENDOSCOPY	0	0	12,521,947	0	2,435
51.00 05100	RECOVERY ROOM	0	0	12,033,588	0	236
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	4,428,022	0	5,054
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	40,875,566	0	1,946
54.01 05401	RADIOLOGY - ULTRASOUND	0	0	22,691,762	0	1,131
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	22,689,787	0	261
55.01 05501	INFUSION CENTER	0	0	130,187	0	0
56.00 05600	RADIOISOTOPE	0	0	16,069,979	0	2
57.00 05700	CT SCAN	0	0	134,797,158	0	1,788
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	31,267,753	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	70,589,396	0	3,280
60.00 06000	LABORATORY	0	1,351,692	223,819,693	0	229
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	12,197,992	0	86
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	0	42,954,297	0	733
66.00 06600	PHYSICAL THERAPY	0	0	7,841,511	0	148
67.00 06700	OCCUPATIONAL THERAPY	0	0	5,715,234	0	62
68.00 06800	SPEECH PATHOLOGY	0	0	2,893,110	0	69
69.00 06900	ELECTROCARDIOLOGY	0	0	25,742,675	0	1,173
69.01 06901	CARDIAC REHAB	0	0	1,096,565	0	8
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	32,608,358	0	688
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,702,025	0	55,185,539	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,677,336	0	35,423,662	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	20,353,721	162,306,726	0	260
74.00 07400	RENAL DIALYSIS	0	0	9,399,418	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	24,028,280	0	240
91.00 09100	EMERGENCY	0	0	88,722,447	29	13,564
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	24,696	3,944,434	0	387
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	25,379,361	21,730,109	1,417,261,476	699	91,116
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	212,028	0	0	1,382

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	
			14.00	15.00	16.00	17.00	17.01	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	46	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,850,254	7,226,343	4,178,915	655,390	549,281	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.191110	0.329336	0.002949	937.610873	5.935350	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	606,565	335,904	208,819	29,179	183,679	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.023900	0.015309	0.000147	41.743920	1.984775	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PROGRAM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.02	21.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00570 ADMITTING						5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 00590 OTHER A&G						5.05
5.06 00592 PATIENT TRANSPORTATION						5.06
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						17.00
17.01 01701 STAFF EDUCATION						17.01
17.02 01702 MEDICAL EDUCATION	100					17.02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100			22.00
23.00 02300 PARAMED PROGRAM	0			100		23.00
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
31.01 03101 NEONATAL ICU	0	0	0	0	0	31.01
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
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01 05001 ENDOSCOPY	0	0	0	0	0	50.01
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 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0	0	0	0	0	55.01
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	100	100	100	100	100	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100	100	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0002

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

Worksheet B-1

Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description	MEDICAL EDUCATION (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMETERED PROGRAM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.02	21.00			
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0	0	0		192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0		192.02
193.00 19300 NONPAID WORKERS	0	0	0	0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	30,225	282,158	254,718	1,227,853		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	302.250000	2,821.580000	2,547.180000	12,278.530000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	6,229	1,045	73,735	63,568		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	62.290000	10.450000	737.350000	635.680000		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 9:02 am
		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		83,469,209	0	83,469,209	30.00
31.00	03100 INTENSIVE CARE UNIT		16,976,791	0	16,976,791	31.00
31.01	03101 NEONATAL ICU		2,894,417	0	2,894,417	31.01
40.00	04000 SUBPROVIDER - IPF		1,815,787	0	1,815,787	40.00
41.00	04100 SUBPROVIDER - IRF		5,176,818	0	5,176,818	41.00
43.00	04300 NURSERY		3,483,536	0	3,483,536	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		16,405,073	0	16,405,073	50.00
50.01	05001 ENDOSCOPY		1,867,097	0	1,867,097	50.01
51.00	05100 RECOVERY ROOM		2,554,938	0	2,554,938	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		6,633,702	0	6,633,702	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,952,671	0	7,952,671	54.00
54.01	05401 RADIOLOGY - ULTRASOUND		2,902,450	0	2,902,450	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		3,916,620	2,561	3,919,181	55.00
55.01	05501 INFUSION CENTER		79,781	0	79,781	55.01
56.00	05600 RADIOISOTOPE		2,787,732	0	2,787,732	56.00
57.00	05700 CT SCAN		4,870,909	0	4,870,909	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,687,734	0	1,687,734	58.00
59.00	05900 CARDIAC CATHETERIZATION		5,825,663	0	5,825,663	59.00
60.00	06000 LABORATORY		19,241,253	0	19,241,253	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		2,218,385	0	2,218,385	62.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	6,086,490	0	6,086,490	65.00
66.00	06600 PHYSICAL THERAPY	0	2,770,198	0	2,770,198	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,250,612	0	2,250,612	67.00
68.00	06800 SPEECH PATHOLOGY	0	819,592	0	819,592	68.00
69.00	06900 ELECTROCARDIOLOGY		1,402,745	0	1,402,745	69.00
69.01	06901 CARDIAC REHAB		676,974	0	676,974	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		2,260,413	0	2,260,413	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		19,697,372	0	19,697,372	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		16,652,092	0	16,652,092	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		32,655,600	0	32,655,600	73.00
74.00	07400 RENAL DIALYSIS		2,903,716	0	2,903,716	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		10,929,976	0	10,929,976	90.00
91.00	09100 EMERGENCY		21,809,345	0	21,809,345	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		14,883,439	0	14,883,439	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		3,457,854	0	3,457,854	101.00
200.00	Subtotal (see instructions)	0	332,016,984	2,561	332,019,545	200.00
201.00	Less Observation Beds		14,883,439		14,883,439	201.00
202.00	Total (see instructions)	0	317,133,545	2,561	317,136,106	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 5/27/2022 9:02 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	80,353,912		80,353,912				30.00
31.00	03100	INTENSIVE CARE UNIT	23,628,573		23,628,573				31.00
31.01	03101	NEONATAL ICU	6,340,767		6,340,767				31.01
40.00	04000	SUBPROVIDER - IPF	2,296,180		2,296,180				40.00
41.00	04100	SUBPROVIDER - IRF	4,463,400		4,463,400				41.00
43.00	04300	NURSERY	1,996,068		1,996,068				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	61,149,104	108,143,802	169,292,906	0.096903	0.000000		50.00
50.01	05001	ENDOSCOPY	4,187,052	8,334,895	12,521,947	0.149106	0.000000		50.01
51.00	05100	RECOVERY ROOM	3,850,256	8,183,332	12,033,588	0.212317	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,837,919	2,590,103	4,428,022	1.498119	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,920,270	30,955,296	40,875,566	0.194558	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	5,666,770	17,024,992	22,691,762	0.127908	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,082,901	21,606,886	22,689,787	0.172616	0.000000		55.00
55.01	05501	INFUSION CENTER	3,400	126,787	130,187	0.612818	0.000000		55.01
56.00	05600	RADIOISOTOPE	5,035,513	11,034,466	16,069,979	0.173475	0.000000		56.00
57.00	05700	CT SCAN	49,862,919	84,934,239	134,797,158	0.036135	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,881,745	19,386,008	31,267,753	0.053977	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	36,533,561	34,055,835	70,589,396	0.082529	0.000000		59.00
60.00	06000	LABORATORY	101,355,213	122,464,480	223,819,693	0.085968	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,760,468	4,437,524	12,197,992	0.181865	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	39,563,740	3,390,557	42,954,297	0.141697	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,908,324	933,187	7,841,511	0.353273	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,174,350	540,884	5,715,234	0.393792	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,607,732	285,378	2,893,110	0.283291	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	13,493,447	12,249,228	25,742,675	0.054491	0.000000		69.00
69.01	06901	CARDIAC REHAB	316,044	780,521	1,096,565	0.617359	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	8,051,747	24,556,611	32,608,358	0.069320	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,629,110	30,556,429	55,185,539	0.356930	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,889,673	19,533,989	35,423,662	0.470084	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,353,584	55,953,142	162,306,726	0.201197	0.000000		73.00
74.00	07400	RENAL DIALYSIS	8,454,465	944,953	9,399,418	0.308925	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	247,282	23,780,998	24,028,280	0.454880	0.000000		90.00
91.00	09100	EMERGENCY	19,268,625	69,453,822	88,722,447	0.245815	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,597,199	21,317,385	26,914,584	0.552988	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,944,434	3,944,434				101.00
200.00		Subtotal (see instructions)	675,761,313	741,500,163	1,417,261,476				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	675,761,313	741,500,163	1,417,261,476				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 9:02 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	03101	NEONATAL ICU		31.01
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	0.096903	50.00
50.01	05001	ENDOSCOPY	0.149106	50.01
51.00	05100	RECOVERY ROOM	0.212317	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172729	55.00
55.01	05501	INFUSION CENTER	0.612818	55.01
56.00	05600	RADIOISOTOPE	0.173475	56.00
57.00	05700	CT SCAN	0.036135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082529	59.00
60.00	06000	LABORATORY	0.085968	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.141697	65.00
66.00	06600	PHYSICAL THERAPY	0.353273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393792	67.00
68.00	06800	SPEECH PATHOLOGY	0.283291	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054491	69.00
69.01	06901	CARDIAC REHAB	0.617359	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	73.00
74.00	07400	RENAL DIALYSIS	0.308925	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.454880	90.00
91.00	09100	EMERGENCY	0.245815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 9:02 am
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		83,469,209	0	83,469,209	30.00
31.00	03100 INTENSIVE CARE UNIT		16,976,791	0	16,976,791	31.00
31.01	03101 NEONATAL ICU		2,894,417	0	2,894,417	31.01
40.00	04000 SUBPROVIDER - I/PF		1,815,787	0	1,815,787	40.00
41.00	04100 SUBPROVIDER - I/RF		5,176,818	0	5,176,818	41.00
43.00	04300 NURSERY		3,483,536	0	3,483,536	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		16,405,073	0	16,405,073	50.00
50.01	05001 ENDOSCOPY		1,867,097	0	1,867,097	50.01
51.00	05100 RECOVERY ROOM		2,554,938	0	2,554,938	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		6,633,702	0	6,633,702	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,952,671	0	7,952,671	54.00
54.01	05401 RADIOLOGY - ULTRASOUND		2,902,450	0	2,902,450	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		3,916,620	2,561	3,919,181	55.00
55.01	05501 INFUSION CENTER		79,781	0	79,781	55.01
56.00	05600 RADIOISOTOPE		2,787,732	0	2,787,732	56.00
57.00	05700 CT SCAN		4,870,909	0	4,870,909	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,687,734	0	1,687,734	58.00
59.00	05900 CARDIAC CATHETERIZATION		5,825,663	0	5,825,663	59.00
60.00	06000 LABORATORY		19,241,253	0	19,241,253	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		2,218,385	0	2,218,385	62.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	6,086,490	0	6,086,490	65.00
66.00	06600 PHYSICAL THERAPY	0	2,770,198	0	2,770,198	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,250,612	0	2,250,612	67.00
68.00	06800 SPEECH PATHOLOGY	0	819,592	0	819,592	68.00
69.00	06900 ELECTROCARDIOLOGY		1,402,745	0	1,402,745	69.00
69.01	06901 CARDIAC REHAB		676,974	0	676,974	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		2,260,413	0	2,260,413	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		19,697,372	0	19,697,372	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		16,652,092	0	16,652,092	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		32,655,600	0	32,655,600	73.00
74.00	07400 RENAL DIALYSIS		2,903,716	0	2,903,716	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		10,929,976	0	10,929,976	90.00
91.00	09100 EMERGENCY		21,809,345	0	21,809,345	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		14,883,439	0	14,883,439	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		3,457,854	0	3,457,854	101.00
200.00	Subtotal (see instructions)	0	332,016,984	2,561	332,019,545	200.00
201.00	Less Observation Beds		14,883,439		14,883,439	201.00
202.00	Total (see instructions)	0	317,133,545	2,561	317,136,106	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet C Part I Date/Time Prepared: 5/27/2022 9:02 am		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	80,353,912		80,353,912				30.00
31.00	03100	INTENSIVE CARE UNIT	23,628,573		23,628,573				31.00
31.01	03101	NEONATAL ICU	6,340,767		6,340,767				31.01
40.00	04000	SUBPROVIDER - IPF	2,296,180		2,296,180				40.00
41.00	04100	SUBPROVIDER - IRF	4,463,400		4,463,400				41.00
43.00	04300	NURSERY	1,996,068		1,996,068				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	61,149,104	108,143,802	169,292,906	0.096903	0.000000		50.00
50.01	05001	ENDOSCOPY	4,187,052	8,334,895	12,521,947	0.149106	0.000000		50.01
51.00	05100	RECOVERY ROOM	3,850,256	8,183,332	12,033,588	0.212317	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,837,919	2,590,103	4,428,022	1.498119	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,920,270	30,955,296	40,875,566	0.194558	0.000000		54.00
54.01	05401	RADIOLOGY - ULTRASOUND	5,666,770	17,024,992	22,691,762	0.127908	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,082,901	21,606,886	22,689,787	0.172616	0.000000		55.00
55.01	05501	INFUSION CENTER	3,400	126,787	130,187	0.612818	0.000000		55.01
56.00	05600	RADIOISOTOPE	5,035,513	11,034,466	16,069,979	0.173475	0.000000		56.00
57.00	05700	CT SCAN	49,862,919	84,934,239	134,797,158	0.036135	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,881,745	19,386,008	31,267,753	0.053977	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	36,533,561	34,055,835	70,589,396	0.082529	0.000000		59.00
60.00	06000	LABORATORY	101,355,213	122,464,480	223,819,693	0.085968	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,760,468	4,437,524	12,197,992	0.181865	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	39,563,740	3,390,557	42,954,297	0.141697	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,908,324	933,187	7,841,511	0.353273	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,174,350	540,884	5,715,234	0.393792	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,607,732	285,378	2,893,110	0.283291	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	13,493,447	12,249,228	25,742,675	0.054491	0.000000		69.00
69.01	06901	CARDIAC REHAB	316,044	780,521	1,096,565	0.617359	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	8,051,747	24,556,611	32,608,358	0.069320	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,629,110	30,556,429	55,185,539	0.356930	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,889,673	19,533,989	35,423,662	0.470084	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,353,584	55,953,142	162,306,726	0.201197	0.000000		73.00
74.00	07400	RENAL DIALYSIS	8,454,465	944,953	9,399,418	0.308925	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	247,282	23,780,998	24,028,280	0.454880	0.000000		90.00
91.00	09100	EMERGENCY	19,268,625	69,453,822	88,722,447	0.245815	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,597,199	21,317,385	26,914,584	0.552988	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0	3,944,434	3,944,434				101.00
200.00		Subtotal (see instructions)	675,761,313	741,500,163	1,417,261,476				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	675,761,313	741,500,163	1,417,261,476				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 9:02 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	03101 NEONATAL ICU			31.01
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	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 INFUSION CENTER	0.000000		55.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Prepared: 5/27/2022 9:02 am
		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	6,083,843	0	6,083,843	81,162	74.96	30.00
31.00	INTENSIVE CARE UNIT	474,104		474,104	9,195	51.56	31.00
31.01	NEONATAL ICU	59,638		59,638	2,460	24.24	31.01
40.00	SUBPROVIDER - IPF	82,155	0	82,155	1,239	66.31	40.00
41.00	SUBPROVIDER - IRF	576,495	0	576,495	4,300	134.07	41.00
43.00	NURSERY	424,528		424,528	2,056	206.48	43.00
200.00	Total (lines 30 through 199)	7,700,763		7,700,763	100,412		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	18,462	1,383,912				30.00
31.00	INTENSIVE CARE UNIT	2,984	153,855				31.00
31.01	NEONATAL ICU	0	0				31.01
40.00	SUBPROVIDER - IPF	422	27,983				40.00
41.00	SUBPROVIDER - IRF	1,987	266,397				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	23,855	1,832,147				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/27/2022 9:02 am
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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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,182,536	169,292,906	0.006985	13,413,691	93,695	50.00
50.01	05001	ENDOSCOPY	26,345	12,521,947	0.002104	1,474,976	3,103	50.01
51.00	05100	RECOVERY ROOM	259,292	12,033,588	0.021547	955,453	20,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,511	4,428,022	0.040540	7,272	295	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	931,913	40,875,566	0.022799	3,310,011	75,465	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	112,872	22,691,762	0.004974	1,411,974	7,023	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	248,649	22,689,787	0.010959	367,910	4,032	55.00
55.01	05501	INFUSION CENTER	6,332	130,187	0.048638	0	0	55.01
56.00	05600	RADIOISOTOPE	170,373	16,069,979	0.010602	1,555,406	16,490	56.00
57.00	05700	CT SCAN	234,192	134,797,158	0.001737	14,734,253	25,593	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	92,872	31,267,753	0.002970	3,471,943	10,312	58.00
59.00	05900	CARDIAC CATHETERIZATION	206,588	70,589,396	0.002927	11,645,073	34,085	59.00
60.00	06000	LABORATORY	601,467	223,819,693	0.002687	28,318,209	76,091	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,096	12,197,992	0.002221	2,038,533	4,528	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	180,098	42,954,297	0.004193	10,731,920	44,999	65.00
66.00	06600	PHYSICAL THERAPY	218,109	7,841,511	0.027815	1,568,779	43,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,097	5,715,234	0.032562	1,065,980	34,710	67.00
68.00	06800	SPEECH PATHOLOGY	35,018	2,893,110	0.012104	827,068	10,011	68.00
69.00	06900	ELECTROCARDIOLOGY	22,953	25,742,675	0.000892	4,162,295	3,713	69.00
69.01	06901	CARDIAC REHAB	4,368	1,096,565	0.003983	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	30,186	32,608,358	0.000926	2,636,227	2,441	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,614	55,185,539	0.008057	7,445,467	59,988	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	372,826	35,423,662	0.010525	5,571,189	58,637	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	515,440	162,306,726	0.003176	27,461,593	87,218	73.00
74.00	07400	RENAL DIALYSIS	88,666	9,399,418	0.009433	3,104,878	29,288	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,309,168	24,028,280	0.054484	40,959	2,232	90.00
91.00	09100	EMERGENCY	695,659	88,722,447	0.007841	5,816,869	45,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,084,809	26,914,584	0.040306	1,944,431	78,372	92.00
200.00		Total (lines 50 through 199)	9,468,049	1,294,238,142		155,082,359	872,154	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			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	
31.01	03101	NEONATAL ICU	0	0	0	0	0	31.01	
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	
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	81,162	0.00	18,462	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	9,195	0.00	2,984	31.00	
31.01	03101	NEONATAL ICU	0	0	2,460	0.00	0	31.01	
40.00	04000	SUBPROVIDER - IPF	0	0	1,239	0.00	422	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	4,300	0.00	1,987	41.00	
43.00	04300	NURSERY	0	0	2,056	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	100,412	0.00	23,855	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
31.01	03101	NEONATAL ICU	0						31.01
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description	Title XVIII				Hospital		Total
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	INFUSION CENTER	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	1,227,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,227,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
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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)	Title XVIII		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				Hospital	PPS		
	4.00	5.00	6.00	Total Charges (from Wkst. C, Part I, col. 8)	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	169,292,906	0.000000	50.00	
50.01 05001 ENDOSCOPY	0	0	0	12,521,947	0.000000	50.01	
51.00 05100 RECOVERY ROOM	0	0	0	12,033,588	0.000000	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,428,022	0.000000	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	40,875,566	0.000000	54.00	
54.01 05401 RADIOLOGY - ULTRASOUND	0	0	0	22,691,762	0.000000	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	22,689,787	0.000000	55.00	
55.01 05501 INFUSION CENTER	0	0	0	130,187	0.000000	55.01	
56.00 05600 RADIOISOTOPE	0	0	0	16,069,979	0.000000	56.00	
57.00 05700 CT SCAN	0	0	0	134,797,158	0.000000	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	31,267,753	0.000000	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	70,589,396	0.000000	59.00	
60.00 06000 LABORATORY	0	0	0	223,819,693	0.000000	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	12,197,992	0.000000	62.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	42,954,297	0.000000	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	7,841,511	0.000000	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	5,715,234	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	2,893,110	0.000000	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	25,742,675	0.000000	69.00	
69.01 06901 CARDIAC REHAB	0	0	0	1,096,565	0.000000	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	32,608,358	0.000000	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	55,185,539	0.000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,423,662	0.000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	162,306,726	0.000000	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	9,399,418	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	24,028,280	0.000000	90.00	
91.00 09100 EMERGENCY	0	1,227,853	1,227,853	88,722,447	0.013839	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	26,914,584	0.000000	92.00	
200.00 Total (lines 50 through 199)	0	1,227,853	1,227,853	1,294,238,142		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	13,413,691	0	18,694,844	0	50.00
50.01	05001 ENDOSCOPY	0.000000	1,474,976	0	1,566,447	0	50.01
51.00	05100 RECOVERY ROOM	0.000000	955,453	0	1,229,776	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	7,272	0	195,211	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	3,310,011	0	5,411,371	0	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.000000	1,411,974	0	1,578,134	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	367,910	0	6,278,287	0	55.00
55.01	05501 INFUSION CENTER	0.000000	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0.000000	1,555,406	0	2,375,120	0	56.00
57.00	05700 CT SCAN	0.000000	14,734,253	0	13,333,744	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,471,943	0	3,403,993	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	11,645,073	0	7,433,853	0	59.00
60.00	06000 LABORATORY	0.000000	28,318,209	0	7,176,749	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	2,038,533	0	223,629	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	10,731,920	0	573,354	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,568,779	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,065,980	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	827,068	0	21,025	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	4,162,295	0	2,114,992	0	69.00
69.01	06901 CARDIAC REHAB	0.000000	0	0	263,274	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	2,636,227	0	6,669,747	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	7,445,467	0	6,327,304	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,571,189	0	4,641,293	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	27,461,593	0	17,683,883	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	3,104,878	0	295,792	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	40,959	0	2,769,074	0	90.00
91.00	09100 EMERGENCY	0.013839	5,816,869	80,500	6,998,165	96,848	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,944,431	0	2,543,715	0	92.00
200.00	Total (lines 50 through 199)		155,082,359	80,500	119,802,776	96,848	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.096903	18,694,844	0	0	1,811,586	50.00
50.01	05001	ENDOSCOPY	0.149106	1,566,447	0	0	233,567	50.01
51.00	05100	RECOVERY ROOM	0.212317	1,229,776	0	0	261,102	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	195,211	0	0	292,449	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	5,411,371	0	0	1,052,826	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	1,578,134	0	0	201,856	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172616	6,278,287	0	0	1,083,733	55.00
55.01	05501	INFUSION CENTER	0.612818	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.173475	2,375,120	0	0	412,024	56.00
57.00	05700	CT SCAN	0.036135	13,333,744	0	0	481,815	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	3,403,993	0	0	183,737	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082529	7,433,853	0	0	613,508	59.00
60.00	06000	LABORATORY	0.085968	7,176,749	0	0	616,971	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	223,629	0	0	40,670	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141697	573,354	0	0	81,243	65.00
66.00	06600	PHYSICAL THERAPY	0.353273	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393792	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.283291	21,025	0	0	5,956	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054491	2,114,992	0	0	115,248	69.00
69.01	06901	CARDIAC REHAB	0.617359	263,274	0	0	162,535	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	6,669,747	0	0	462,347	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	6,327,304	0	0	2,258,405	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	4,641,293	0	0	2,181,798	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	17,683,883	0	19,881	3,557,944	73.00
74.00	07400	RENAL DIALYSIS	0.308925	295,792	0	0	91,378	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.454880	2,769,074	0	0	1,259,596	90.00
91.00	09100	EMERGENCY	0.245815	6,998,165	0	0	1,720,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	2,543,715	0	0	1,406,644	92.00
200.00		Subtotal (see instructions)		119,802,776	0	19,881	20,589,192	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		119,802,776	0	19,881	20,589,192	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
50.01	05001 ENDOSCOPY	0	0	50.01
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 RADIOLOGY - ULTRASOUND	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501 INFUSION CENTER	0	0	55.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,000	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
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
200.00	Subtotal (see instructions)	0	4,000	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	4,000	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/27/2022 9:02 am
	Title XVIII	Subprovider - IPF	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	1,182,536	169,292,906	0.006985	0	0	50.00
50.01 05001 ENDOSCOPY	26,345	12,521,947	0.002104	3,097	7	50.01
51.00 05100 RECOVERY ROOM	259,292	12,033,588	0.021547	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	179,511	4,428,022	0.040540	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	931,913	40,875,566	0.022799	9,413	215	54.00
54.01 05401 RADIOLOGY - ULTRASOUND	112,872	22,691,762	0.004974	7,187	36	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	248,649	22,689,787	0.010959	0	0	55.00
55.01 05501 INFUSION CENTER	6,332	130,187	0.048638	0	0	55.01
56.00 05600 RADIO SOTOPE	170,373	16,069,979	0.010602	1,552	16	56.00
57.00 05700 CT SCAN	234,192	134,797,158	0.001737	16,721	29	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	92,872	31,267,753	0.002970	10,755	32	58.00
59.00 05900 CARDIAC CATHETERIZATION	206,588	70,589,396	0.002927	0	0	59.00
60.00 06000 LABORATORY	601,467	223,819,693	0.002687	163,376	439	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	27,096	12,197,992	0.002221	11,082	25	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	180,098	42,954,297	0.004193	1,501	6	65.00
66.00 06600 PHYSICAL THERAPY	218,109	7,841,511	0.027815	1,500	42	66.00
67.00 06700 OCCUPATIONAL THERAPY	186,097	5,715,234	0.032562	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	35,018	2,893,110	0.012104	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	22,953	25,742,675	0.000892	22,541	20	69.00
69.01 06901 CARDIAC REHAB	4,368	1,096,565	0.003983	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	30,186	32,608,358	0.000926	2,053	2	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	444,614	55,185,539	0.008057	1,843	15	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	372,826	35,423,662	0.010525	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	515,440	162,306,726	0.003176	232,461	738	73.00
74.00 07400 RENAL DIALYSIS	88,666	9,399,418	0.009433	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,309,168	24,028,280	0.054484	0	0	90.00
91.00 09100 EMERGENCY	695,659	88,722,447	0.007841	23,910	187	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	26,914,584	0.000000	0	0	92.00
200.00 Total (lines 50 through 199)	8,383,240	1,294,238,142		508,992	1,809	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
Title XVIII		Subprovider - IPF	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
50.01 05001 ENDOSCOPY	0	0	0	0	0	50.01
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 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 05501 INFUSION CENTER	0	0	0	0	0	55.01
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	1,227,853	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	1,227,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	169,292,906	0.000000	50.00
50.01	05001 ENDOSCOPY	0	0	0	12,521,947	0.000000	50.01
51.00	05100 RECOVERY ROOM	0	0	0	12,033,588	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,428,022	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	40,875,566	0.000000	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	22,691,762	0.000000	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	22,689,787	0.000000	55.00
55.01	05501 INFUSION CENTER	0	0	0	130,187	0.000000	55.01
56.00	05600 RADIOISOTOPE	0	0	0	16,069,979	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	134,797,158	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	31,267,753	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	70,589,396	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	223,819,693	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	12,197,992	0.000000	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	42,954,297	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	7,841,511	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	5,715,234	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2,893,110	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	25,742,675	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	1,096,565	0.000000	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	32,608,358	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	55,185,539	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,423,662	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	162,306,726	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	9,399,418	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	24,028,280	0.000000	90.00
91.00	09100 EMERGENCY	0	1,227,853	1,227,853	88,722,447	0.013839	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	26,914,584	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,227,853	1,227,853	1,294,238,142		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
Title XVIII		Subprovider - IPF	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	0	0	0 50.00
50.01	05001	ENDOSCOPY	0.000000	3,097	0	0 50.01
51.00	05100	RECOVERY ROOM	0.000000	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	9,413	0	0 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.000000	7,187	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0 55.00
55.01	05501	INFUSION CENTER	0.000000	0	0	0 55.01
56.00	05600	RADIO SOTOPE	0.000000	1,552	0	0 56.00
57.00	05700	CT SCAN	0.000000	16,721	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	10,755	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0 59.00
60.00	06000	LABORATORY	0.000000	163,376	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	11,082	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,501	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,500	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,541	0	0 69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,053	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,843	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	232,461	0	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0 90.00
91.00	09100	EMERGENCY	0.013839	23,910	331	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0 92.00
200.00		Total (lines 50 through 199)		508,992	331	0 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part II Date/Time Prepared: 5/27/2022 9:02 am		
Title XVIII				Subprovider - IRF		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	1,182,536	169,292,906	0.006985	225,447	1,575	50.00
50.01	05001	ENDOSCOPY	26,345	12,521,947	0.002104	12,497	26	50.01
51.00	05100	RECOVERY ROOM	259,292	12,033,588	0.021547	7,269	157	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,511	4,428,022	0.040540	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	931,913	40,875,566	0.022799	42,683	973	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	112,872	22,691,762	0.004974	17,369	86	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	248,649	22,689,787	0.010959	0	0	55.00
55.01	05501	INFUSION CENTER	6,332	130,187	0.048638	0	0	55.01
56.00	05600	RADIO SOTOPE	170,373	16,069,979	0.010602	23,332	247	56.00
57.00	05700	CT SCAN	234,192	134,797,158	0.001737	119,437	207	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	92,872	31,267,753	0.002970	37,785	112	58.00
59.00	05900	CARDIAC CATHETERIZATION	206,588	70,589,396	0.002927	20,686	61	59.00
60.00	06000	LABORATORY	601,467	223,819,693	0.002687	634,989	1,706	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	27,096	12,197,992	0.002221	14,232	32	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	180,098	42,954,297	0.004193	255,010	1,069	65.00
66.00	06600	PHYSICAL THERAPY	218,109	7,841,511	0.027815	1,054,565	29,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,097	5,715,234	0.032562	881,888	28,716	67.00
68.00	06800	SPEECH PATHOLOGY	35,018	2,893,110	0.012104	183,376	2,220	68.00
69.00	06900	ELECTROCARDIOLOGY	22,953	25,742,675	0.000892	25,091	22	69.00
69.01	06901	CARDIAC REHAB	4,368	1,096,565	0.003983	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	30,186	32,608,358	0.000926	2,053	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	444,614	55,185,539	0.008057	73,702	594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	372,826	35,423,662	0.010525	24,905	262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	515,440	162,306,726	0.003176	1,174,381	3,730	73.00
74.00	07400	RENAL DIALYSIS	88,666	9,399,418	0.009433	171,521	1,618	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,309,168	24,028,280	0.054484	0	0	90.00
91.00	09100	EMERGENCY	695,659	88,722,447	0.007841	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	26,914,584	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	8,383,240	1,294,238,142		5,002,218	72,748	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
Title XVIII		Subprovider - IRF	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
50.01	05001 ENDOSCOPY	0	0	0	0	0	50.01
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 RADIOLOGY - ULTRASOUND	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 INFUSION CENTER	0	0	0	0	0	55.01
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	1,227,853	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	1,227,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	169,292,906	0.000000	50.00
50.01	05001 ENDOSCOPY	0	0	0	12,521,947	0.000000	50.01
51.00	05100 RECOVERY ROOM	0	0	0	12,033,588	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	4,428,022	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	40,875,566	0.000000	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0	0	0	22,691,762	0.000000	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	22,689,787	0.000000	55.00
55.01	05501 INFUSION CENTER	0	0	0	130,187	0.000000	55.01
56.00	05600 RADIOISOTOPE	0	0	0	16,069,979	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	134,797,158	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	31,267,753	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	70,589,396	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	223,819,693	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	12,197,992	0.000000	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	42,954,297	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	7,841,511	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	5,715,234	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	2,893,110	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	25,742,675	0.000000	69.00
69.01	06901 CARDIAC REHAB	0	0	0	1,096,565	0.000000	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	32,608,358	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	55,185,539	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,423,662	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	162,306,726	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	9,399,418	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	24,028,280	0.000000	90.00
91.00	09100 EMERGENCY	0	1,227,853	1,227,853	88,722,447	0.013839	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	26,914,584	0.000000	92.00
200.00	Total (lines 50 through 199)	0	1,227,853	1,227,853	1,294,238,142		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/27/2022 9:02 am	
				Title XVIII		Subprovider - IRF	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	225,447	0	0	50.00
50.01	05001	ENDOSCOPY	0.000000	12,497	0	0	50.01
51.00	05100	RECOVERY ROOM	0.000000	7,269	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	42,683	0	0	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.000000	17,369	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
55.01	05501	INFUSION CENTER	0.000000	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0.000000	23,332	0	0	56.00
57.00	05700	CT SCAN	0.000000	119,437	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	37,785	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	20,686	0	0	59.00
60.00	06000	LABORATORY	0.000000	634,989	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	14,232	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	255,010	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,054,565	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	881,888	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	183,376	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	25,091	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	2,053	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	73,702	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	24,905	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,174,381	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	171,521	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.013839	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,002,218	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		81,162	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		81,162	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)		66,690	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)		18,462	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)		83,469,209	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)		83,469,209	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)		83,469,209	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)		1,028.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,986,875	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)		18,986,875	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am
				Title XVIII	Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	16,976,791	9,195	1,846.31	2,984	5,509,389	43.00
43.01 NEONATAL ICU	2,894,417	2,460	1,176.59	0	0	43.01
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)					24,800,622	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49,296,886	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)					1,537,767	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					952,654	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,490,421	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					46,806,465	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)					14,472	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,028.43	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					14,883,439	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
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	6,083,843	83,469,209	0.072887	14,883,439	1,084,809	90.00
91.00	Nursing Program cost	0	83,469,209	0.000000	14,883,439	0	91.00
92.00	Allied health cost	0	83,469,209	0.000000	14,883,439	0	92.00
93.00	All other Medical Education	0	83,469,209	0.000000	14,883,439	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Subprovider - IPF	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)		1,239	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,239	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)		1,239	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)		422	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)		1,815,787	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)		1,815,787	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)		1,815,787	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)		1,465.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		618,454	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)		618,454	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 15-S002		Date/Time Prepared: 5/27/2022 9:02 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)					76,144		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					694,598		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)					27,983		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,140		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					30,123		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					664,475		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)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII		Subprovider - IPF		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	82,155	1,815,787	0.045245	0	0	90.00
91.00	Nursing Program cost	0	1,815,787	0.000000	0	0	91.00
92.00	Allied health cost	0	1,815,787	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,815,787	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Subprovider - IRF	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)		4,300	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,300	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)		4,300	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)		1,987	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)		5,176,818	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)		5,176,818	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)		5,176,818	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)		1,203.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,392,169	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,392,169	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 15-T002	Date/Time Prepared: 5/27/2022 9:02 am		
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,241,769		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,633,938		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)					266,397		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					72,748		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					339,145		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,294,793		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)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII		Subprovider - IRF		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	576,495	5,176,818	0.111361	0	0	90.00
91.00	Nursing Program cost	0	5,176,818	0.000000	0	0	91.00
92.00	Allied health cost	0	5,176,818	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,176,818	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2022 9:02 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		81,162	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		81,162	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)		66,690	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)		3,312	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)		2,056	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)		83,469,209	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)		83,469,209	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)		83,469,209	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)		1,028.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,406,160	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,406,160	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description			Title XIX		Hospital	Cost
	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)	3,483,536	2,056	1,694.33	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	16,976,791	9,195	1,846.31	0	43.00
43.01	NEONATAL ICU	2,894,417	2,460	1,176.59	0	43.01
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				2,813,282	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				6,219,442	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				14,472	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,028.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				14,883,439	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
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	6,083,843	83,469,209	0.072887	14,883,439	1,084,809	90.00
91.00	Nursing Program cost	0	83,469,209	0.000000	14,883,439	0	91.00
92.00	Allied health cost	0	83,469,209	0.000000	14,883,439	0	92.00
93.00	All other Medical Education	0	83,469,209	0.000000	14,883,439	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,239 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,239 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)			1,239 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)			58 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)			2,056 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)			1,815,787 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)			1,815,787 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)			1,815,787 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)			1,465.53 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			85,001 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)			85,001 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1	
		Component CCN: 15-S002				Date/Time Prepared: 5/27/2022 9:02 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					33,306		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					118,307		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-S002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	82,155	1,815,787	0.045245	0	0	90.00
91.00	Nursing Program cost	0	1,815,787	0.000000	0	0	91.00
92.00	Allied health cost	0	1,815,787	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,815,787	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,300 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,300 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)			4,300 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)			129 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)			2,056 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)			5,176,818 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)			5,176,818 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)			5,176,818 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)			1,203.91 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			155,304 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)			155,304 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1	
				Component CCN: 15-T002	Date/Time Prepared: 5/27/2022 9:02 am		
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL ICU	0	0	0.00	0	0	0	43.01
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)					214,597		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					369,901		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002 Component CCN: 15-T002		Period: From 01/01/2021 To 12/31/2021		Worksheet D-1 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	576,495	5,176,818	0.111361	0	0	90.00
91.00	Nursing Program cost	0	5,176,818	0.000000	0	0	91.00
92.00	Allied health cost	0	5,176,818	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,176,818	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:02 am	
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		21,814,682	30.00
31.00	03100	INTENSIVE CARE UNIT		7,613,480	31.00
31.01	03101	NEONATAL ICU		0	31.01
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	0.096903	13,413,691	50.00
50.01	05001	ENDOSCOPY	0.149106	1,474,976	50.01
51.00	05100	RECOVERY ROOM	0.212317	955,453	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	7,272	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	3,310,011	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	1,411,974	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172729	367,910	55.00
55.01	05501	INFUSION CENTER	0.612818	0	55.01
56.00	05600	RADIOISOTOPE	0.173475	1,555,406	56.00
57.00	05700	CT SCAN	0.036135	14,734,253	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	3,471,943	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082529	11,645,073	59.00
60.00	06000	LABORATORY	0.085968	28,318,209	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	2,038,533	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141697	10,731,920	65.00
66.00	06600	PHYSICAL THERAPY	0.353273	1,568,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393792	1,065,980	67.00
68.00	06800	SPEECH PATHOLOGY	0.283291	827,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054491	4,162,295	69.00
69.01	06901	CARDIAC REHAB	0.617359	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	2,636,227	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	7,445,467	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	5,571,189	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	27,461,593	73.00
74.00	07400	RENAL DIALYSIS	0.308925	3,104,878	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.454880	40,959	90.00
91.00	09100	EMERGENCY	0.245815	5,816,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	1,944,431	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		155,082,359	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)		155,082,359	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII	Subprovider - IPF	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
31.01	03101	NEONATAL ICU			31.01
40.00	04000	SUBPROVIDER - IPF		799,986	40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.096903	0	0
50.01	05001	ENDOSCOPY	0.149106	3,097	462
51.00	05100	RECOVERY ROOM	0.212317	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	9,413	1,831
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	7,187	919
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172729	0	0
55.01	05501	INFUSION CENTER	0.612818	0	0
56.00	05600	RADIOISOTOPE	0.173475	1,552	269
57.00	05700	CT SCAN	0.036135	16,721	604
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	10,755	581
59.00	05900	CARDIAC CATHETERIZATION	0.082529	0	0
60.00	06000	LABORATORY	0.085968	163,376	14,045
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	11,082	2,015
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	0.141697	1,501	213
66.00	06600	PHYSICAL THERAPY	0.353273	1,500	530
67.00	06700	OCCUPATIONAL THERAPY	0.393792	0	0
68.00	06800	SPEECH PATHOLOGY	0.283291	0	0
69.00	06900	ELECTROCARDIOLOGY	0.054491	22,541	1,228
69.01	06901	CARDIAC REHAB	0.617359	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	2,053	142
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	1,843	658
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	232,461	46,770
74.00	07400	RENAL DIALYSIS	0.308925	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.454880	0	0
91.00	09100	EMERGENCY	0.245815	23,910	5,877
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		508,992	76,144
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		508,992	76,144

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII	Subprovider - IRF	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
31.01	03101	NEONATAL ICU			31.01
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY		2,088,139	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.096903	225,447	50.00
50.01	05001	ENDOSCOPY	0.149106	12,497	50.01
51.00	05100	RECOVERY ROOM	0.212317	7,269	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	42,683	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	17,369	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172729	0	55.00
55.01	05501	INFUSION CENTER	0.612818	0	55.01
56.00	05600	RADIOISOTOPE	0.173475	23,332	56.00
57.00	05700	CT SCAN	0.036135	119,437	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	37,785	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082529	20,686	59.00
60.00	06000	LABORATORY	0.085968	634,989	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	14,232	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141697	255,010	65.00
66.00	06600	PHYSICAL THERAPY	0.353273	1,054,565	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393792	881,888	67.00
68.00	06800	SPEECH PATHOLOGY	0.283291	183,376	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054491	25,091	69.00
69.01	06901	CARDIAC REHAB	0.617359	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	2,053	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	73,702	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	24,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	1,174,381	73.00
74.00	07400	RENAL DIALYSIS	0.308925	171,521	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.454880	0	90.00
91.00	09100	EMERGENCY	0.245815	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,002,218	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)		5,002,218	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,615,985	30.00
31.00	03100	INTENSIVE CARE UNIT		683,970	31.00
31.01	03101	NEONATAL ICU		698,102	31.01
40.00	04000	SUBPROVIDER - IPF		79,338	40.00
41.00	04100	SUBPROVIDER - IRF		88,510	41.00
43.00	04300	NURSERY		219,118	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.096903	2,440,942	236,535 50.00
50.01	05001	ENDOSCOPY	0.149106	122,486	18,263 50.01
51.00	05100	RECOVERY ROOM	0.212317	144,761	30,735 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	291,068	436,055 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	295,557	57,503 54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	212,878	27,229 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172616	23,907	4,127 55.00
55.01	05501	INFUSION CENTER	0.612818	0	0 55.01
56.00	05600	RADIOISOTOPE	0.173475	143,413	24,879 56.00
57.00	05700	CT SCAN	0.036135	1,521,526	54,980 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	370,649	20,007 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082529	1,192,781	98,439 59.00
60.00	06000	LABORATORY	0.085968	3,672,619	315,728 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	61,634	11,209 62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.141697	1,331,216	188,629 65.00
66.00	06600	PHYSICAL THERAPY	0.353273	143,029	50,528 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393792	108,175	42,598 67.00
68.00	06800	SPEECH PATHOLOGY	0.283291	48,701	13,797 68.00
69.00	06900	ELECTROCARDIOLOGY	0.054491	376,949	20,540 69.00
69.01	06901	CARDIAC REHAB	0.617359	6,792	4,193 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	291,277	20,191 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	267,908	95,624 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	267,908	125,939 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	3,328,310	669,646 73.00
74.00	07400	RENAL DIALYSIS	0.308925	154,280	47,661 74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.454880	7,017	3,192 90.00
91.00	09100	EMERGENCY	0.245815	793,504	195,055 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,619,287	2,813,282 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		17,619,287	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3	
		Component CCN: 15-S002		Date/Time Prepared: 5/27/2022 9:02 am	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL ICU			31.01
40.00	04000	SUBPROVIDER - IPF		409,545	40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.096903	0	50.00
50.01	05001	ENDOSCOPY	0.149106	0	50.01
51.00	05100	RECOVERY ROOM	0.212317	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.498119	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194558	5,812	54.00
54.01	05401	RADIOLOGY - ULTRASOUND	0.127908	4,073	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.172616	0	55.00
55.01	05501	INFUSION CENTER	0.612818	0	55.01
56.00	05600	RADIOISOTOPE	0.173475	0	56.00
57.00	05700	CT SCAN	0.036135	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.053977	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.082529	0	59.00
60.00	06000	LABORATORY	0.085968	85,786	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	7,625	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.141697	0	65.00
66.00	06600	PHYSICAL THERAPY	0.353273	1,189	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.393792	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.283291	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.054491	8,364	69.00
69.01	06901	CARDIAC REHAB	0.617359	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.069320	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	16	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470084	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201197	92,786	73.00
74.00	07400	RENAL DIALYSIS	0.308925	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.454880	0	90.00
91.00	09100	EMERGENCY	0.245815	13,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		219,246	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)		219,246	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/27/2022 9:02 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		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
31.01	03101 NEONATAL ICU				31.01
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY		385,970		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.096903	0	0	50.00
50.01	05001 ENDOSCOPY	0.149106	0	0	50.01
51.00	05100 RECOVERY ROOM	0.212317	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.498119	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.194558	6,766	1,316	54.00
54.01	05401 RADIOLOGY - ULTRASOUND	0.127908	3,235	414	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.172616	0	0	55.00
55.01	05501 INFUSION CENTER	0.612818	0	0	55.01
56.00	05600 RADIOISOTOPE	0.173475	1,752	304	56.00
57.00	05700 CT SCAN	0.036135	25,251	912	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.053977	4,674	252	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.082529	0	0	59.00
60.00	06000 LABORATORY	0.085968	125,201	10,763	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.181865	7,304	1,328	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.141697	9,065	1,284	65.00
66.00	06600 PHYSICAL THERAPY	0.353273	186,448	65,867	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.393792	164,405	64,741	67.00
68.00	06800 SPEECH PATHOLOGY	0.283291	27,253	7,721	68.00
69.00	06900 ELECTROCARDIOLOGY	0.054491	6,356	346	69.00
69.01	06901 CARDIAC REHAB	0.617359	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.069320	331	23	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.356930	5,942	2,121	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.470084	5,820	2,736	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201197	228,233	45,920	73.00
74.00	07400 RENAL DIALYSIS	0.308925	25,217	7,790	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.454880	52	24	90.00
91.00	09100 EMERGENCY	0.245815	2,992	735	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.552988	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		836,297	214,597	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)		836,297		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 9:02 am
		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)		24,239,334	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,191,662	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)		1,106,412	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		463,809	2.04
3.00	Managed Care Simulated Payments		29,257,814	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		376.52	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)		8.53	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)		8.53	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.00	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)		3.00	12.00
13.00	Total allowable FTE count for the prior year.		3.00	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.		3.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		3.00	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		3.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.007968	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.007423	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.007423	21.00
22.00	IME payment adjustment (see instructions)		127,296	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		118,494	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)		-5.53	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)		127,296	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		118,494	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.90	30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.33	31.00
32.00	Sum of lines 30 and 31		41.23	32.00
33.00	Allowable disproportionate share percentage (see instructions)		23.23	33.00
34.00	Disproportionate share adjustment (see instructions)		1,825,355	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		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)	3,595,654	3,496,630	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,689,351	881,343	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,570,694		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)	38,524,562		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)		38,643,056	49.00
50.00	Payment for inpatient program capital (From Wkst. L, Pt. I and Pt. II, as applicable)		2,705,090	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).		92,479	52.00
53.00	Nursing and Allied Health Managed Care payment		56,781	53.00
54.00	Special add-on payments for new technologies		541,828	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 instructions)		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)		80,500	58.00
59.00	Total (sum of amounts on lines 49 through 58)		42,119,734	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		42,119,734	61.00
62.00	Deductibles billed to program beneficiaries		2,846,240	62.00
63.00	Coinurance billed to program beneficiaries		470,552	63.00
64.00	Allowable bad debts (see instructions)		643,742	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		418,432	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		39,221,374	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	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)		-42,173	70.93
70.94	HRR adjustment amount (see instructions)		-404,235	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			38,774,966	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			37,671,554	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			1,103,412	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			985,142	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	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	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	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
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2022 9:02 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	24,239,334	0	24,239,334		24,239,334	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,191,662	0		7,191,662	7,191,662	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1,106,412	0	1,106,412		1,106,412	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	463,809	0		463,809	463,809	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	29,257,814	0	22,190,513	7,067,301	29,257,814	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007423	0.007423	0.007423	0.007423		5.00
6.00	IME payment adjustment (see instructions)	22.00	127,296	0	98,170	29,126	127,296	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	118,494	0	89,871	28,623	118,494	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	127,296	0	98,170	29,126	127,296	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	118,494	0	89,871	28,623	118,494	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2323	0.2323	0.2323	0.2323		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,825,355	0	1,407,699	417,656	1,825,355	11.00
11.01	Uncompensated care payments	36.00	3,570,694	0	2,689,351	881,343	3,570,694	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	38,524,562	0	29,540,966	8,983,596	38,524,562	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	38,643,056	0	29,630,837	9,012,219	38,643,056	15.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0002

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2022 9:02 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,705,090	0	2,092,560	612,530	2,705,090	16.00
17.00	Special add-on payments for new technologies	54.00	541,828	0	334,740	207,088	541,828	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	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	32,058,137	9,831,837	41,889,974	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,401,235	0	1,864,976	536,259	2,401,235	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	85,342	0	57,870	27,472	85,342	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0039	0.0039	0.0039	0.0039		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	9,365	0	7,274	2,091	9,365	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0871	0.0871	0.0871	0.0871		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	209,148	0	162,440	46,708	209,148	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,705,090	0	2,092,560	612,530	2,705,090	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2022 9:02 am		
			Title XVIII		Hospital		PPS	
		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	24,239,334	24,239,334			24,239,334	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,191,662		7,191,662		7,191,662	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	1,106,412	1,106,412			1,106,412	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	463,809		463,809		463,809	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0		0	3.00
4.00	Managed care simulated payments	3.00	29,257,814	22,190,513	7,067,301		29,257,814	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.007423	0.007423	0.007423			5.00
6.00	IME payment adjustment (see instructions)	22.00	127,296	98,170	29,126		127,296	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	118,494	89,871	28,623		118,494	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	127,296	98,170	29,126		127,296	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	118,494	89,871	28,623		118,494	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2323	0.2323	0.2323			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,825,355	1,407,699	417,656		1,825,355	11.00
11.01	Uncompensated care payments	36.00	3,570,694	2,689,351	881,343		3,570,694	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	38,524,562	29,540,966	8,983,596		38,524,562	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	38,643,056	29,630,837	9,012,219		38,643,056	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,705,090	2,092,560	612,530		2,705,090	16.00
17.00	Special add-on payments for new technologies	54.00	541,828	334,740	207,088		541,828	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			32,058,137	9,831,837		41,889,974	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII		Hospital		PPS	
		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	2,401,235	1,864,976	536,259	2,401,235	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	85,342	57,870	27,472	85,342	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	0.0039	0.0039	0.0039		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	9,365	7,274	2,091	9,365	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0871	0.0871	0.0871		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	209,148	162,440	46,708	209,148	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,705,090	2,092,560	612,530	2,705,090	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	-42,173	-42,173	0	-42,173	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	-404,235	-329,293	-74,942	-404,235	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,000	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		20,492,344	2.00
3.00	OPPS payments		17,661,811	3.00
4.00	Outlier payment (see instructions)		265,073	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		96,848	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,000	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		19,881	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)		19,881	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 charge basis 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)		19,881	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		15,881	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)		4,000	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)		18,023,732	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,634,501	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)		15,393,231	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		35,501	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)		15,428,732	30.00
31.00	Primary payer payments		7,792	31.00
32.00	Subtotal (line 30 minus line 31)		15,420,940	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)		322,535	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		209,648	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		15,630,588	37.00
38.00	MSP-LCC reconciliation amount from PS&R		244	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	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)		15,630,344	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		0	40.03
41.00	Interim payments		16,001,433	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-371,089	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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: 15-0002		Period: From 01/01/2021 To 12/31/2021		Worksheet E-1 Part I Date/Time Prepared: 5/27/2022 9:02 am	
		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		36,657,663		15,285,773	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/31/2021	780,691	12/31/2021	715,660		3.01
3.02		12/31/2021	233,200		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)		1,013,891		715,660		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)		37,671,554		16,001,433		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		1,103,412		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		371,089		6.02
7.00	Total Medicare program liability (see instructions)		38,774,966		15,630,344		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0002

Period: From 01/01/2021

Worksheet E-1

Component CCN: 15-S002

To 12/31/2021

Part I
Date/Time Prepared:
5/27/2022 9:02 am

Title XVIII

Subprovider -
IPF

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		336,867		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		336,867		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		18,228		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		355,095		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII	Subprovider - IRF	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				0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,586,771		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,586,771		0 4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		27,334		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		3,614,105		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Hospital	PPS
		1.00		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part II Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			369,439 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			3.394521 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			369,439 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			369,439 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			369,439 18.00
19.00	Deductibles			32,572 19.00
20.00	Subtotal (line 18 minus line 19)			336,867 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			336,867 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			27,534 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			17,897 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			354,764 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			331 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			355,095 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			336,867 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			18,228 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part III Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,298,636 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0777 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			234,533 3.00
4.00	Outlier Payments			106,068 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.780822 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,639,237 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,639,237 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,639,237 19.00
20.00	Deductibles			13,356 20.00
21.00	Subtotal (line 19 minus line 20)			3,625,881 21.00
22.00	Coinurance			16,695 22.00
23.00	Subtotal (line 21 minus line 22)			3,609,186 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			7,568 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			4,919 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,614,105 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,614,105 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,586,771 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			27,334 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			106,068 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 9:02 am	
		Title XIX	Hospital	Cost	
			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		6,219,442		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,219,442	0	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)		6,219,442	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		4,385,022		8.00
9.00	Ancillary service charges		17,619,287	0	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)		22,004,309	0	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)		22,004,309	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		15,784,867	0	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)		6,219,442	0	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)		6,219,442	0	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)		6,219,442	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		6,219,442	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		6,219,442	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)		6,219,442	0	40.00
41.00	Interim payments		7,366,501	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-1,147,059	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-S002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 9:02 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 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	118,307		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	118,307	0	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)	118,307	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	409,545		8.00
9.00	Ancillary service charges	219,246	0	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)	628,791	0	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)	628,791	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	510,484	0	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)	118,307	0	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	118,307	0	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)	118,307	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	118,307	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	118,307	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	118,307	0	40.00
41.00	Interim payments	210,504	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-92,197	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 Component CCN: 15-T002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 9:02 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 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	369,901		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	369,901	0	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)	369,901	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	385,970		8.00
9.00	Ancillary service charges	836,297	0	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)	1,222,267	0	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)	1,222,267	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	852,366	0	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)	369,901	0	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	369,901	0	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)	369,901	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	369,901	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	369,901	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	369,901	0	40.00
41.00	Interim payments	409,186	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-39,285	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/27/2022 9:02 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			10.83	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			10.83	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.00	6.00
7.00	Enter the lesser of line 5 or line 6			3.00	7.00
		Primary Care 1.00	Other 2.00	Total 3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.53	2.53	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.53	2.53	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.53		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	2.50		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	2.50		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.51		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	2.51		17.00
18.00	Per resident amount	92,787.39	92,787.39		18.00
19.00	Approved amount for resident costs	0	232,896	232,896	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			92,787.39	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			232,896	25.00
		Inpatient Part A 1.00	Managed Care 2.00	Total 3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	23,855	23,224		26.00
27.00	Total Inpatient Days (see instructions)	83,954	83,954		27.00
28.00	Ratio of inpatient days to total inpatient days	0.284144	0.276628		28.00
29.00	Program direct GME amount	66,176	64,426	130,602	29.00
29.01	Percent reduction for MA DGME		4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,622	2,622	30.00
31.00	Net Program direct GME amount			127,980	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		9,399,418	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		53,625,422	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		53,625,422	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		20,593,192	42.00
43.00	Primary payer payments (see instructions)		7,792	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		20,585,400	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		74,210,822	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.722609	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.277391	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		127,980	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		92,479	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		35,501	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0002

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

Worksheet G

Date/Time Prepared:
5/27/2022 9:02 am

		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	103,986,573	0	0	0	1.00
2.00	Temporary investments	617,043	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	44,297,264	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	13,135,392	0	0	0	7.00
8.00	Prepaid expenses	4,617,356	0	0	0	8.00
9.00	Other current assets	18,770,540	0	0	0	9.00
10.00	Due from other funds	112,750	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	185,536,918	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,373,674	0	0	0	12.00
13.00	Land improvements	6,958,207	0	0	0	13.00
14.00	Accumulated depreciation	-397,185,511	0	0	0	14.00
15.00	Buildings	309,357,738	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,230,154	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	211,798,957	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	137,533,219	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	125,730,753	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	387,086	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	126,117,839	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	449,187,976	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	25,275,478	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-287	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,690,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	56,128,197	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	84,093,388	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	32,939,220	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	50,050,845	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	82,990,065	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	167,083,453	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	282,104,523				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)	282,104,523	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	449,187,976	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0002

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

Worksheet G-1

Date/Time Prepared:
5/27/2022 9:02 am

		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		266,439,110		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		15,665,413				2.00
3.00	Total (sum of line 1 and line 2)		282,104,523		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		282,104,523		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)		282,104,523		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	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: 15-0002

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2022 9:02 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	80,568,821		80,568,821	1.00
2.00	SUBPROVIDER - IPF	2,296,207		2,296,207	2.00
3.00	SUBPROVIDER - IRF	4,463,507		4,463,507	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	87,328,535		87,328,535	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	30,128,086		30,128,086	11.00
11.01	NEONATAL ICU	0		0	11.01
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)	30,128,086		30,128,086	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	117,456,621		117,456,621	17.00
18.00	Ancillary services	529,241,750	637,383,540	1,166,625,290	18.00
19.00	Outpatient services	24,246,764	104,997,780	129,244,544	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		3,944,434	3,944,434	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL REVENUES	449,663	52,071,058	52,520,721	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	671,394,798	798,396,812	1,469,791,610	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		383,956,915		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)		383,956,915		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0002

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

Worksheet G-3

Date/Time Prepared:
5/27/2022 9:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,469,791,610	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,107,150,452	2.00
3.00	Net patient revenues (line 1 minus line 2)	362,641,158	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	383,956,915	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-21,315,757	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,893,071	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 OPERATING INCOME	9,467,301	24.00
24.01	NON OPERATING INCOME	389,235	24.01
24.02	CHANGE IN UNREALIZED GAIN/LOSS	3,977,198	24.02
24.03	REALIZED GAIN/LOSS ON INVESTMENT SAL	-5,230	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL	59,300	24.04
24.50	COVID-19 PHE Funding	18,426,305	24.50
25.00	Total other income (sum of lines 6-24)	37,207,180	25.00
26.00	Total (line 5 plus line 25)	15,891,423	26.00
27.00	FOUNDATION SALARIES	210,878	27.00
27.01	FOUNDATION OTHER	15,132	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	226,010	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,665,413	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0002

Period: From 01/01/2021

Worksheet H

HHA CCN: 15-7536

To 12/31/2021

Date/Time Prepared: 5/27/2022 9:02 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	560,394	0	0	428,950	989,344	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	933,120	0	0	0	933,120	6.00
7.00	Physical Therapy	450,219	0	0	0	450,219	7.00
8.00	Occupational Therapy	159,101	0	0	0	159,101	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	2,992	0	0	0	2,992	10.00
11.00	Home Health Aide	61,574	0	0	0	61,574	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,167,400	0	0	428,950	2,596,350	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-27,710	961,634	0	961,634		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	933,120	0	933,120		6.00
7.00	Physical Therapy	0	450,219	0	450,219		7.00
8.00	Occupational Therapy	0	159,101	0	159,101		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	2,992	0	2,992		10.00
11.00	Home Health Aide	0	61,574	0	61,574		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-27,710	2,568,640	0	2,568,640		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2021 To 12/31/2021		Worksheet H-1 Part I Date/Time Prepared: 5/27/2022 9:02 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	961,634	0	0	0	961,634	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	933,120	0	0	0	933,120	6.00
7.00	Physical Therapy	450,219	0	0	0	450,219	7.00
8.00	Occupational Therapy	159,101	0	0	0	159,101	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	2,992	0	0	0	2,992	10.00
11.00	Home Health Aide	61,574	0	0	0	61,574	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,568,640	0	0	0	2,568,640	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	961,634					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	558,381	1,491,501				6.00
7.00	Physical Therapy	269,411	719,630				7.00
8.00	Occupational Therapy	95,206	254,307				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	1,790	4,782				10.00
11.00	Home Health Aide	36,846	98,420				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		2,568,640				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0002

Period: From 01/01/2021

Worksheet H-1

HHA CCN: 15-7536

To 12/31/2021

Part II
Date/Time Prepared:
5/27/2022 9:02 am

Home Health
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-961,634	1,607,006
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	933,120
7.00	Physical Therapy	0	0	0	0	0	450,219
8.00	Occupational Therapy	0	0	0	0	0	159,101
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	2,992
11.00	Home Health Aide	0	0	0	0	0	61,574
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-961,634	1,607,006
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		961,634
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.598401

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2021

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2021

Part I
Date/Time Prepared: 5/27/2022 9:02 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02	5.03	
1.00 Administrative and General	0		0	485,495	0	9,875	10,062	1.00
2.00 Skilled Nursing Care	1,491,501		0	0	0	0	0	2.00
3.00 Physical Therapy	719,630		0	0	0	0	0	3.00
4.00 Occupational Therapy	254,307		0	0	0	0	0	4.00
5.00 Speech Pathology	0		0	0	0	0	0	5.00
6.00 Medical Social Services	4,782		0	0	0	0	0	6.00
7.00 Home Health Aide	98,420		0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0		0	0	0	0	0	8.00
9.00 Drugs	0		0	0	0	0	0	9.00
10.00 DME	0		0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0		0	0	0	0	0	11.00
12.00 Respiratory Therapy	0		0	0	0	0	0	12.00
13.00 Private Duty Nursing	0		0	0	0	0	0	13.00
14.00 Clinic	0		0	0	0	0	0	14.00
15.00 Health Promotion Activities	0		0	0	0	0	0	15.00
16.00 Day Care Program	0		0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0		0	0	0	0	0	17.00
18.00 Homemaker Service	0		0	0	0	0	0	18.00
19.00 All Others (specify)	0		0	0	0	0	0	19.00
19.50 Telemedicine	0		0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	2,568,640		0	485,495	0	9,875	10,062	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00
Cost Center Description	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER A&G	PATIENT TRANSPORTATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	5.04	5A.04	5.05	5.06	7.00	8.00		
1.00 Administrative and General	20,681	526,113	57,977	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	1,491,501	164,362	0	0	0	0	2.00
3.00 Physical Therapy	0	719,630	79,303	0	0	0	0	3.00
4.00 Occupational Therapy	0	254,307	28,024	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	4,782	527	0	0	0	0	6.00
7.00 Home Health Aide	0	98,420	10,846	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	20,681	3,094,753	341,039	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2021

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2021

Part I Date/Time Prepared: 5/27/2022 9:02 am

Home Health Agency I

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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	8,133	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	8,133	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	STAFF EDUCATION	MEDICAL EDUCATION	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS	
		16.00	17.00	17.01	17.02	21.00	22.00	
1.00	Administrative and General	11,632	0	2,297	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	11,632	0	2,297	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0002

Period: From 01/01/2021

Worksheet H-2

HHA CCN: 15-7536

To 12/31/2021

Part I
Date/Time Prepared:
5/27/2022 9:02 am

Home Health Agency I

PPS

Cost Center Description	PARAMED ED PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	23.00	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	606,152	0	606,152			1.00
2.00 Skilled Nursing Care	0	1,655,863	0	1,655,863	351,967	2,007,830	2.00
3.00 Physical Therapy	0	798,933	0	798,933	169,820	968,753	3.00
4.00 Occupational Therapy	0	282,331	0	282,331	60,012	342,343	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	5,309	0	5,309	1,128	6,437	6.00
7.00 Home Health Aide	0	109,266	0	109,266	23,225	132,491	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	0	3,457,854	0	3,457,854	606,152	3,457,854	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.212558		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet H-2 Part II Date/Time Prepared: 5/27/2022 9:02 am
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (PURCHASE REQUIREMENTS)	ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0	2,167,399	0	0	122,473	3,944,434	3,944,434	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,167,399	0	0	122,473	3,944,434	3,944,434	20.00
21.00 Total cost to be allocated	0	485,495	0	0	9,875	10,062	20,681	21.00
22.00 Unit cost multiplier	0.000000	0.223999	0.000000	0.080630	0.002551	0.005243		22.00

Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATION (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)							
								5A.05	5.05	5.06	7.00	8.00	9.00
								1.00 Administrative and General	0	526,113	0	0	0
2.00 Skilled Nursing Care	0	1,491,501	0	0	0	0	2.00						
3.00 Physical Therapy	0	719,630	0	0	0	0	3.00						
4.00 Occupational Therapy	0	254,307	0	0	0	0	4.00						
5.00 Speech Pathology	0	0	0	0	0	0	5.00						
6.00 Medical Social Services	0	4,782	0	0	0	0	6.00						
7.00 Home Health Aide	0	98,420	0	0	0	0	7.00						
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00						
9.00 Drugs	0	0	0	0	0	0	9.00						
10.00 DME	0	0	0	0	0	0	10.00						
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00						
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00						
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00						
14.00 Clinic	0	0	0	0	0	0	14.00						
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00						
16.00 Day Care Program	0	0	0	0	0	0	16.00						
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00						
18.00 Homemaker Service	0	0	0	0	0	0	18.00						
19.00 All Others (specify)	0	0	0	0	0	0	19.00						
19.50 Telemedicine	0	0	0	0	0	0	19.50						
20.00 Total (sum of lines 1-19)		3,094,753	0	0	0	0	20.00						
21.00 Total cost to be allocated		341,039	0	0	0	0	21.00						
22.00 Unit cost multiplier		0.110199	0.000000	0.000000	0.000000	0.000000	22.00						

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet H-2 Part II Date/Time Prepared: 5/27/2022 9:02 am
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (PRODUCTIVE HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	24,696	3,944,434	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	24,696	3,944,434	20.00
21.00	Total cost to be allocated	0	0	0	0	8,133	11,632	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.329325	0.002949	22.00

Cost Center Description		INTERNS & RESIDENTS						
		SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	MEDICAL EDUCATION (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED PROGRAM (ASSIGNED TIME)	
		17.00	17.01	17.02	21.00	22.00	23.00	
1.00	Administrative and General	0	387	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	387	0	0	0	0	20.00
21.00	Total cost to be allocated	0	2,297	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.935401	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet H-3 Part I Date/Time Prepared: 5/27/2022 9:02 am
				Title XVIII	Home Health Agency I	PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	2,007,830		2,007,830	12,534	160.19	1.00
2.00	Physical Therapy	3.00	968,753	0	968,753	4,824	200.82	2.00
3.00	Occupational Therapy	4.00	342,343	0	342,343	1,788	191.47	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	6,437		6,437	44	146.30	5.00
6.00	Home Health Aide	7.00	132,491		132,491	2,134	62.09	6.00
7.00	Total (sum of lines 1-6)		3,457,854	0	3,457,854	21,324		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits			Ratio (col. 3 ÷ col. 4)
			Part A	Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
0	1.00	2.00	3.00	4.00	5.00	

Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0	3,515		8.00
9.00	Physical Therapy		23844	0	1,436		9.00
10.00	Occupational Therapy		23844	0	617		10.00
11.00	Speech Pathology		23844	0	0		11.00
12.00	Medical Social Services		23844	0	9		12.00
13.00	Home Health Aide		23844	0	676		13.00
14.00	Total (sum of lines 8-13)			0	6,253		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (From HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00		8.00	9.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,515		0	563,068	1.00
2.00	Physical Therapy	0	1,436		0	288,378	2.00
3.00	Occupational Therapy	0	617		0	118,137	3.00
4.00	Speech Pathology	0	0		0	0	4.00
5.00	Medical Social Services	0	9		0	1,317	5.00
6.00	Home Health Aide	0	676		0	41,973	6.00
7.00	Total (sum of lines 1-6)	0	6,253		0	1,012,873	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 15-0002 HHA CCN: 15-7536		Period: From 01/01/2021 To 12/31/2021		Worksheet H-3 Part I Date/Time Prepared: 5/27/2022 9:02 am	
			Title XVIII		Home Health Agency I		PPS	
Cost Center Description			6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00
Program Covered Charges			Part B		Cost of Services			
Cost Center Description			Part A	Part B		Part A	Part B	
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
			6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	207,097	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	563,068						
2.00	Physical Therapy	288,378						
3.00	Occupational Therapy	118,137						
4.00	Speech Pathology	0						
5.00	Medical Social Services	1,317						
6.00	Home Health Aide	41,973						
7.00	Total (sum of lines 1-6)	1,012,873						
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet H-3 Part II Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.353273	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.393792	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.283291	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.356930	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.201197	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet H-4 Part I-II Date/Time Prepared: 5/27/2022 9:02 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
		Part A Services	Part B Services	
		1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	863,458	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	88,051	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	12,604	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,894	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	15,433	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	981,440	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	981,440	24.00
25.00	Coinurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	981,440	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	981,440	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	981,440	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	981,440	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0002 HHA CCN: 15-7536	Period: From 01/01/2021 To 12/31/2021	Worksheet H-5 Date/Time Prepared: 5/27/2022 9:02 am PPS
		Home Health Agency I	

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		981,440	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			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			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. H-4, Part II, column as appropriate, line 32)		0		981,440	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		981,440	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0002	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/27/2022 9:02 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,401,235	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		85,342	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)		214.84	3.00
4.00	Number of interns & residents (see instructions)		3.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.39	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)		9,365	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		8.90	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		32.33	8.00
9.00	Sum of lines 7 and 8		41.23	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.71	10.00
11.00	Disproportionate share adjustment (see instructions)		209,148	11.00
12.00	Total prospective capital payments (see instructions)		2,705,090	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