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: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet S Parts I-III Date/Time Prepared: 6/1/2022 10:58 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 6/1/2022 Time: 10:58 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RH OF NORTHWEST INDIANA, LLC (15-2024) for the cost reporting period beginning 02/01/2021 and ending 01/31/2022 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	Scott Romberger		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Scott Romberger			2
3	Signatory Title	VICE PRESIDENT			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-548,406	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-548,406	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2022 10:58 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4321 FIR STREET, 4TH FLOOR	PO Box:			1.00
2.00	City: EAST CHICAGO	State: IN	Zip Code: 46312	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	RH OF NORTHWEST INDIANA, LLC	152024	23844	2	02/01/2004	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	02/01/2021	01/31/2022	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2022 10:58 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet S-2 Part I Date/Time Prepared: 6/1/2022 10:58 am

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

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

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

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

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

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

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

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

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

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					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.				Y	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.				Y	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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.06
	Rural Providers					
105.00	Does this hospital qualify as a CAH?			N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2022 10:58 am

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	178,235	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0312	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2022 10:58 am

	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: NAME: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC.	Contractor's Number: 12001	141.00
142.00	Street: STREET: 4714 GETTYSBURG ROAD	PO Box:		142.00
143.00	City: CITY: MECHANICSBURG	State: PA	Zip Code: 17055	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 6/1/2022 10:58 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	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 6/1/2022 10:58 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.	Y		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	ANDREW	BUTZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	SELECT MEDICAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-972-1391	APBUTZ@SELECTMEDICAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet S-2 Part II Date/Time Prepared: 6/1/2022 10:58 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.	REIMBURSEMENT ANALYST		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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 6/1/2022 10:58 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	61	22,265	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)		61	22,265	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		61	22,265	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		61				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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2022 10:58 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,819	0	14,400			1.00
2.00	HMO and other (see instructions)	1,874	2,045				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,819	0	14,400			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	7,819	0	14,400	0.00	130.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	130.00	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	28					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2022 10:58 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	332	0	597	1.00
2.00	HMO and other (see instructions)			67	72		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	332	0	597	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 6/1/2022 10:58 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	10,804,157	0	10,804,157	270,390.05	39.96	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	41,443	41,443	1,327.53	31.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,052,220	0	4,052,220	36,158.13	112.07	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		142,406	0	142,406	660.62	215.56	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,085,379	0	1,085,379	20,242.00	53.62	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,847,847	0	1,847,847			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		75,539	0	75,539			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		186,978	0	186,978			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 6/1/2022 10:58 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	55,905	0	55,905	1,171.44	47.72	26.00
27.00	Administrative & General	5.00	2,010,700	-41,443	1,969,257	39,169.13	50.28	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	89,204	0	89,204	2,753.38	32.40	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	651,570	0	651,570	10,697.33	60.91	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	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	139,008	0	139,008	6,246.64	22.25	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 6/1/2022 10:58 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		10,804,157	0	10,804,157	270,390.05	39.96	1.00
2.00	Excluded area salaries (see instructions)		0	41,443	41,443	1,327.53	31.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)		10,804,157	-41,443	10,762,714	269,062.52	40.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,280,005	0	5,280,005	57,060.75	92.53	4.00
5.00	Subtotal wage-related costs (see inst.)		2,034,825	0	2,034,825	0.00	18.91	5.00
6.00	Total (sum of lines 3 thru 5)		18,118,987	-41,443	18,077,544	326,123.27	55.43	6.00
7.00	Total overhead cost (see instructions)		2,946,387	-41,443	2,904,944	60,037.92	48.39	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 6/1/2022 10:58 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	66,027	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	689,876	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	12,747	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,838	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	225,465	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	781,472	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	19,044	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	29,378	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,847,847	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A | Date/Time Prepared: 6/1/2022 10:58 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	946,684	946,684	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,517,221	1,517,221	-1,163,410	353,811	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	55,905	14,581	70,486	23,838	94,324	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,010,700	1,708,863	3,719,563	134,466	3,854,029	5.00
7.00	00700	OPERATION OF PLANT	0	4,319	4,319	0	4,319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,463	76,463	0	76,463	8.00
9.00	00900	HOUSEKEEPING	0	4,400	4,400	0	4,400	9.00
10.00	01000	DIETARY	89,204	268,033	357,237	0	357,237	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	651,570	132,656	784,226	0	784,226	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,008	34,227	173,235	0	173,235	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,226,721	4,738,295	9,965,016	0	9,965,016	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,398	508,070	510,468	-75,285	435,183	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	317,551	317,551	75,285	392,836	54.00
60.00	06000	LABORATORY	0	1,221,738	1,221,738	0	1,221,738	60.00
65.00	06500	RESPIRATORY THERAPY	1,079,692	685,304	1,764,996	-38,931	1,726,065	65.00
66.00	06600	PHYSICAL THERAPY	390,630	105,140	495,770	0	495,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,343	21,658	230,001	0	230,001	67.00
68.00	06800	SPEECH PATHOLOGY	127,314	35,242	162,556	0	162,556	68.00
69.00	06900	ELECTROCARDIOLOGY	0	46,357	46,357	0	46,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	118,237	1,449,149	1,567,386	38,931	1,606,317	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	704,435	1,081,983	1,786,418	0	1,786,418	73.00
74.00	07400	RENAL DIALYSIS	0	540,919	540,919	0	540,919	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,804,157	14,512,169	25,316,326	-58,422	25,257,904	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	58,422	58,422	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	10,804,157	14,512,169	25,316,326	0	25,316,326	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A | Date/Time Prepared: 6/1/2022 10:58 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	0	946,684		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	74,522	428,333		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	94,324		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,405,147	5,259,176		5.00
7.00	00700	OPERATION OF PLANT	0	4,319		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,463		8.00
9.00	00900	HOUSEKEEPING	0	4,400		9.00
10.00	01000	DIETARY	0	357,237		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	784,226		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-275	172,960		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-25,315	9,939,701		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	435,183		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	392,836		54.00
60.00	06000	LABORATORY	0	1,221,738		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,726,065		65.00
66.00	06600	PHYSICAL THERAPY	0	495,770		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	230,001		67.00
68.00	06800	SPEECH PATHOLOGY	0	162,556		68.00
69.00	06900	ELECTROCARDIOLOGY	0	46,357		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,606,317		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,786,418		73.00
74.00	07400	RENAL DIALYSIS	0	540,919		74.00
76.00	03950	WOUND CARE	0	0		76.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,454,079	26,711,983		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PROVIDER RELATIONS NRCC	0	58,422		194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	1,454,079	26,770,405		200.00

RECLASSIFICATIONS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-6 | Date/Time Prepared: 6/1/2022 10:58 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - FACILITY RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	946,684		1.00
	TOTALS		0	946,684		
	B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,838		1.00
	TOTALS		0	23,838		
	C - CAPITAL RECONCILIATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	216,726		1.00
	TOTALS		0	216,726		
	D - PROVIDER RELATIONS NRCC					
1.00	PROVIDER RELATIONS NRCC	194.00	41,443	16,979		1.00
	TOTALS		41,443	16,979		
	E - PICC LINE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75,285		1.00
	TOTALS		0	75,285		
	F - OXYGEN TANK RENTAL					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38,931		1.00
	TOTALS		0	38,931		
500.00	Grand Total: Increases		41,443	1,318,443		500.00

RECLASSIFICATIONS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-6 | Date/Time Prepared: 6/1/2022 10:58 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - FACILITY RENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	946,684	10	1.00
	TOTALS		0	946,684		
	B - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,838	0	1.00
	TOTALS		0	23,838		
	C - CAPITAL RECONCILIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	216,726	12	1.00
	TOTALS		0	216,726		
	D - PROVIDER RELATIONS NRCC					
1.00	ADMINISTRATIVE & GENERAL	5.00	41,443	16,979	0	1.00
	TOTALS		41,443	16,979		
	E - PICC LINE RECLASS					
1.00	OPERATING ROOM	50.00	0	75,285	0	1.00
	TOTALS		0	75,285		
	F - OXYGEN TANK RENTAL					
1.00	RESPIRATORY THERAPY	65.00	0	38,931	0	1.00
	TOTALS		0	38,931		
500.00	Grand Total: Decreases		41,443	1,318,443		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 6/1/2022 10:58 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	274,696	10,070	0	10,070	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	3,257,606	528,080	0	528,080	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,532,302	538,150	0	538,150	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,532,302	538,150	0	538,150	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	284,766	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	3,785,686	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,070,452	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	4,070,452	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 6/1/2022 10:58 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
2.00	CAP REL COSTS-MVBLE EQUIP	315,069	938,699	3,591	225,248	34,614	2.00
3.00	Total (sum of lines 1-2)	315,069	938,699	3,591	225,248	34,614	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,517,221		2.00
3.00	Total (sum of lines 1-2)	0	1,517,221		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 6/1/2022 10:58 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	284,766	0	284,766	0.069959	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,785,686	0	3,785,686	0.930041	0	2.00
3.00	Total (sum of lines 1-2)	4,070,452	0	4,070,452	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	0	946,684	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	389,591	-7,985	2.00
3.00	Total (sum of lines 1-2)	0	0	0	389,591	938,699	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	946,684	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,591	8,522	34,614	0	428,333	2.00
3.00	Total (sum of lines 1-2)	3,591	8,522	34,614	0	1,375,017	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-8 | Date/Time Prepared: 6/1/2022 10:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-25,315			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	987,100			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-8 | Date/Time Prepared: 6/1/2022 10:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
35.00	OTHER PERSONNAL EXPENSE	A	-54,858	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	AHA DUES	A	-1,033	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MEDICAL RECORDS INCOME	B	-275	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	REVERSE OF GL EXP CR FOR CARES	B	548,460	ADMINISTRATIVE & GENERAL	5.00	0	38.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,454,079				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 6/1/2022 10:58 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	74,522	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1,576,450	663,872	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,650,972	663,872	5.00

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

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

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

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

6.00	B		0.00	SELECT MEDICAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 6/1/2022 10:58 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	74,522	9		1.00
2.00	912,578	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	987,100			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 6/1/2022 10:58 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	30.00	DR. A	10,148	0	10,148	211,500	62	1.00
2.00	30.00	DR. B	18,000	0	18,000	211,500	120	2.00
3.00	30.00	DR. C	12,500	0	12,500	211,500	100	3.00
4.00	30.00	DR. D	12,500	0	12,500	211,500	100	4.00
5.00	30.00	DR. E	10,240	0	10,240	211,500	64	5.00
6.00	30.00	DR. F	12,219	0	12,219	211,500	91	6.00
7.00	30.00	DR. G	1,075	0	1,075	211,500	9	7.00
8.00	30.00	DR. H	4,200	0	4,200	211,500	28	8.00
9.00	30.00	DR. I	15,000	0	15,000	211,500	120	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			95,882	0	95,882		694	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	6,304	315	0	0	0	1.00
2.00	30.00	DR. B	12,202	610	0	0	0	2.00
3.00	30.00	DR. C	10,168	508	0	0	0	3.00
4.00	30.00	DR. D	10,168	508	0	0	0	4.00
5.00	30.00	DR. E	6,508	325	0	0	0	5.00
6.00	30.00	DR. F	9,253	463	0	0	0	6.00
7.00	30.00	DR. G	915	46	0	0	0	7.00
8.00	30.00	DR. H	2,847	142	0	0	0	8.00
9.00	30.00	DR. I	12,202	610	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			70,567	3,527	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	6,304	3,844	3,844		1.00
2.00	30.00	DR. B	0	12,202	5,798	5,798		2.00
3.00	30.00	DR. C	0	10,168	2,332	2,332		3.00
4.00	30.00	DR. D	0	10,168	2,332	2,332		4.00
5.00	30.00	DR. E	0	6,508	3,732	3,732		5.00
6.00	30.00	DR. F	0	9,253	2,966	2,966		6.00
7.00	30.00	DR. G	0	915	160	160		7.00
8.00	30.00	DR. H	0	2,847	1,353	1,353		8.00
9.00	30.00	DR. I	0	12,202	2,798	2,798		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	70,567	25,315	25,315		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part I Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	946,684	946,684				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	428,333		428,333			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,324	4,761	2,154	101,239		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,259,176	125,647	56,850	18,548	5,460,221	5.00
7.00	00700	OPERATION OF PLANT	4,319	283,666	128,346	0	416,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,463	14,916	6,749	0	98,128	8.00
9.00	00900	HOUSEKEEPING	4,400	8,664	3,920	0	16,984	9.00
10.00	01000	DIETARY	357,237	7,395	3,346	840	368,818	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	784,226	8,156	3,690	6,137	802,209	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	172,960	5,110	2,312	1,309	181,691	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,939,701	406,679	184,004	49,233	10,579,617	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	435,183	0	0	23	435,206	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	392,836	0	0	0	392,836	54.00
60.00	06000	LABORATORY	1,221,738	5,554	2,513	0	1,229,805	60.00
65.00	06500	RESPIRATORY THERAPY	1,726,065	11,901	5,385	10,170	1,753,521	65.00
66.00	06600	PHYSICAL THERAPY	495,770	6,633	3,001	3,679	509,083	66.00
67.00	06700	OCCUPATIONAL THERAPY	230,001	6,633	3,001	1,962	241,597	67.00
68.00	06800	SPEECH PATHOLOGY	162,556	3,015	1,364	1,199	168,134	68.00
69.00	06900	ELECTROCARDIOLOGY	46,357	0	0	0	46,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,606,317	23,358	10,569	1,114	1,641,358	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,786,418	22,692	10,267	6,635	1,826,012	73.00
74.00	07400	RENAL DIALYSIS	540,919	0	0	0	540,919	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,711,983	944,780	427,471	100,849	26,708,827	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	58,422	1,904	862	390	61,578	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,770,405	946,684	428,333	101,239	26,770,405	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part I Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,460,221					5.00
7.00	00700	OPERATION OF PLANT	106,675	523,006				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,143	14,647	137,918			8.00
9.00	00900	HOUSEKEEPING	4,352	8,508	0	29,844		9.00
10.00	01000	DIETARY	94,501	7,261	0	434	471,014	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	205,547	8,009	0	478	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,554	5,018	0	300	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,710,769	399,345	137,918	23,842	471,014	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,511	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,655	0	0	0	0	54.00
60.00	06000	LABORATORY	315,108	5,454	0	326	0	60.00
65.00	06500	RESPIRATORY THERAPY	449,298	11,687	0	698	0	65.00
66.00	06600	PHYSICAL THERAPY	130,440	6,513	0	389	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,903	6,513	0	389	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,080	2,961	0	177	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,878	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	420,559	22,937	0	1,369	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	467,872	22,283	0	1,330	0	73.00
74.00	07400	RENAL DIALYSIS	138,598	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,444,443	521,136	137,918	29,732	471,014	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	15,778	1,870	0	112	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,460,221	523,006	137,918	29,844	471,014	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part I Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,016,243				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	233,563			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,016,243	81,539	15,420,287	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,245	547,962	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,636	498,127	0	54.00
60.00	06000	LABORATORY	0	0	15,257	1,565,950	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	72,408	2,287,612	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,916	650,341	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,827	313,229	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,244	215,596	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,043	66,278	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,471	2,106,694	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,612	2,334,109	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	5,365	684,882	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,016,243	233,563	26,691,067	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	79,338	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,016,243	233,563	26,770,405	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part I Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	15,420,287		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	547,962		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,127		54.00
60.00	06000	LABORATORY	1,565,950		60.00
65.00	06500	RESPIRATORY THERAPY	2,287,612		65.00
66.00	06600	PHYSICAL THERAPY	650,341		66.00
67.00	06700	OCCUPATIONAL THERAPY	313,229		67.00
68.00	06800	SPEECH PATHOLOGY	215,596		68.00
69.00	06900	ELECTROCARDIOLOGY	66,278		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,106,694		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,334,109		73.00
74.00	07400	RENAL DIALYSIS	684,882		74.00
76.00	03950	WOUND CARE	0		76.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,691,067		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	79,338		194.00
194.01	07951	NRCC SUBLEASED SPACE	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	26,770,405		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part II Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,761	2,154	6,915	6,915	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	132	125,647	56,850	182,629	1,266	5.00
7.00	00700	OPERATION OF PLANT	0	283,666	128,346	412,012	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,916	6,749	21,665	0	8.00
9.00	00900	HOUSEKEEPING	0	8,664	3,920	12,584	0	9.00
10.00	01000	DIETARY	0	7,395	3,346	10,741	57	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,156	3,690	11,846	419	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,110	2,312	7,422	89	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	406,679	184,004	590,683	3,365	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	2	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	5,554	2,513	8,067	0	60.00
65.00	06500	RESPIRATORY THERAPY	38,931	11,901	5,385	56,217	694	65.00
66.00	06600	PHYSICAL THERAPY	0	6,633	3,001	9,634	251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,633	3,001	9,634	134	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,015	1,364	4,379	82	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	276,322	23,358	10,569	310,249	76	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,692	10,267	32,959	453	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	315,385	944,780	427,471	1,687,636	6,888	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	1,904	862	2,766	27	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	315,385	946,684	428,333	1,690,402	6,915	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part II Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	183,895					5.00
7.00	00700	OPERATION OF PLANT	3,593	415,605				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	847	11,640	34,152			8.00
9.00	00900	HOUSEKEEPING	147	6,761	0	19,492		9.00
10.00	01000	DIETARY	3,183	5,770	0	283	20,034	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,922	6,365	0	312	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,568	3,987	0	196	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,299	317,336	34,152	15,573	20,034	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,755	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,390	0	0	0	0	54.00
60.00	06000	LABORATORY	10,612	4,334	0	213	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,131	9,287	0	456	0	65.00
66.00	06600	PHYSICAL THERAPY	4,393	5,176	0	254	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,085	5,176	0	254	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,451	2,353	0	115	0	68.00
69.00	06900	ELECTROCARDIOLOGY	400	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,163	18,227	0	894	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,757	17,707	0	869	0	73.00
74.00	07400	RENAL DIALYSIS	4,668	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	183,364	414,119	34,152	19,419	20,034	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	531	1,486	0	73	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	183,895	415,605	34,152	19,492	20,034	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part II Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	25,864				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	13,262			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,864	4,616	1,102,922	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	71	3,828	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	264	3,654	0	54.00
60.00	06000	LABORATORY	0	0	868	24,094	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,117	85,902	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	223	19,931	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	161	17,444	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	71	8,451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	457	857	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,164	344,773	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	945	68,690	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	305	4,973	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	25,864	13,262	1,685,519	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	4,883	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	25,864	13,262	1,690,402	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B Part II Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,102,922		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,828		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,654		54.00
60.00	06000	LABORATORY	24,094		60.00
65.00	06500	RESPIRATORY THERAPY	85,902		65.00
66.00	06600	PHYSICAL THERAPY	19,931		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,444		67.00
68.00	06800	SPEECH PATHOLOGY	8,451		68.00
69.00	06900	ELECTROCARDIOLOGY	857		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,773		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,690		73.00
74.00	07400	RENAL DIALYSIS	4,973		74.00
76.00	03950	WOUND CARE	0		76.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,685,519		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	4,883		194.00
194.01	07951	NRCC SUBLEASED SPACE	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,690,402		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	29,829					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		29,829				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	150	150	10,748,252			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,959	3,959	1,969,257	-5,460,221	21,310,184	5.00
7.00	00700	OPERATION OF PLANT	8,938	8,938	0	0	416,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	470	470	0	0	98,128	8.00
9.00	00900	HOUSEKEEPING	273	273	0	0	16,984	9.00
10.00	01000	DIETARY	233	233	89,204	0	368,818	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	257	257	651,570	0	802,209	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	161	139,008	0	181,691	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,814	12,814	5,226,721	0	10,579,617	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,398	0	435,206	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	392,836	54.00
60.00	06000	LABORATORY	175	175	0	0	1,229,805	60.00
65.00	06500	RESPIRATORY THERAPY	375	375	1,079,692	0	1,753,521	65.00
66.00	06600	PHYSICAL THERAPY	209	209	390,630	0	509,083	66.00
67.00	06700	OCCUPATIONAL THERAPY	209	209	208,343	0	241,597	67.00
68.00	06800	SPEECH PATHOLOGY	95	95	127,314	0	168,134	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	46,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736	736	118,237	0	1,641,358	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715	715	704,435	0	1,826,012	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	540,919	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,769	29,769	10,706,809	-5,460,221	21,248,606	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	60	60	41,443	0	61,578	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	946,684	428,333	101,239		5,460,221	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.737034	14.359616	0.009419		0.256226	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,915		183,895	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000643		0.008629	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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	16,782					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	470	15,672				8.00
9.00	00900	HOUSEKEEPING	273	0	16,039			9.00
10.00	01000	DIETARY	233	0	233	15,672		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	257	0	257	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	0	161	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,814	15,672	12,814	15,672	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	175	0	175	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	375	0	375	0	0	65.00
66.00	06600	PHYSICAL THERAPY	209	0	209	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209	0	209	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	95	0	95	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	736	0	736	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715	0	715	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,722	15,672	15,979	15,672	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	60	0	60	0	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	523,006	137,918	29,844	471,014	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.164700	8.800281	1.860715	30.054492	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	415,605	34,152	19,492	20,034	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.764927	2.179173	1.215288	1.278331	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet B-1 | Date/Time Prepared: 6/1/2022 10:58 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	72			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	189,660,371		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	72	66,164,627		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,011,061		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,766,391		54.00
60.00	06000	LABORATORY	0	12,393,791		60.00
65.00	06500	RESPIRATORY THERAPY	0	58,820,243		65.00
66.00	06600	PHYSICAL THERAPY	0	3,181,220		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,296,901		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,010,559		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,533,324		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,629,303		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,494,478		73.00
74.00	07400	RENAL DIALYSIS	0	4,358,473		74.00
76.00	03950	WOUND CARE	0	0		76.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72	189,660,371		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PROVIDER RELATIONS NRCC	0	0		194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,016,243	233,563		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14,114.486111	0.001231		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,864	13,262		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	359.222222	0.000070		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,420,287		15,420,287	25,315	15,445,602	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	547,962		547,962	0	547,962	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,127		498,127	0	498,127	54.00
60.00	06000	LABORATORY	1,565,950		1,565,950	0	1,565,950	60.00
65.00	06500	RESPIRATORY THERAPY	2,287,612	0	2,287,612	0	2,287,612	65.00
66.00	06600	PHYSICAL THERAPY	650,341	0	650,341	0	650,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,229	0	313,229	0	313,229	67.00
68.00	06800	SPEECH PATHOLOGY	215,596	0	215,596	0	215,596	68.00
69.00	06900	ELECTROCARDIOLOGY	66,278		66,278	0	66,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,106,694		2,106,694	0	2,106,694	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,334,109		2,334,109	0	2,334,109	73.00
74.00	07400	RENAL DIALYSIS	684,882		684,882	0	684,882	74.00
76.00	03950	WOUND CARE	0		0	0	0	76.00
200.00		Subtotal (see instructions)	26,691,067	0	26,691,067	25,315	26,716,382	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,691,067	0	26,691,067	25,315	26,716,382	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,164,627		66,164,627			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,011,061	0	1,011,061	0.541967	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,766,391	0	3,766,391	0.132256	0.000000	54.00
60.00	06000	LABORATORY	12,393,791	0	12,393,791	0.126350	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	58,820,243	0	58,820,243	0.038892	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,181,220	0	3,181,220	0.204431	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,296,901	0	2,296,901	0.136370	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,010,559	0	1,010,559	0.213343	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,533,324	0	6,533,324	0.010145	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,629,303	0	16,629,303	0.126686	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,494,478	0	13,494,478	0.172968	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,358,473	0	4,358,473	0.157138	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0.000000	0.000000	76.00
200.00		Subtotal (see instructions)	189,660,371	0	189,660,371			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	189,660,371	0	189,660,371			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.541967		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132256		54.00
60.00	06000	LABORATORY	0.126350		60.00
65.00	06500	RESPIRATORY THERAPY	0.038892		65.00
66.00	06600	PHYSICAL THERAPY	0.204431		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.136370		67.00
68.00	06800	SPEECH PATHOLOGY	0.213343		68.00
69.00	06900	ELECTROCARDIOLOGY	0.010145		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.126686		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172968		73.00
74.00	07400	RENAL DIALYSIS	0.157138		74.00
76.00	03950	WOUND CARE	0.000000		76.00
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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,420,287		15,420,287	25,315	15,445,602	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	547,962		547,962	0	547,962	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,127		498,127	0	498,127	54.00
60.00	06000	LABORATORY	1,565,950		1,565,950	0	1,565,950	60.00
65.00	06500	RESPIRATORY THERAPY	2,287,612	0	2,287,612	0	2,287,612	65.00
66.00	06600	PHYSICAL THERAPY	650,341	0	650,341	0	650,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,229	0	313,229	0	313,229	67.00
68.00	06800	SPEECH PATHOLOGY	215,596	0	215,596	0	215,596	68.00
69.00	06900	ELECTROCARDIOLOGY	66,278		66,278	0	66,278	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,106,694		2,106,694	0	2,106,694	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,334,109		2,334,109	0	2,334,109	73.00
74.00	07400	RENAL DIALYSIS	684,882		684,882	0	684,882	74.00
76.00	03950	WOUND CARE	0		0	0	0	76.00
200.00		Subtotal (see instructions)	26,691,067	0	26,691,067	25,315	26,716,382	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	26,691,067	0	26,691,067	25,315	26,716,382	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,164,627		66,164,627			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,011,061	0	1,011,061	0.541967	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,766,391	0	3,766,391	0.132256	0.000000	54.00
60.00	06000	LABORATORY	12,393,791	0	12,393,791	0.126350	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	58,820,243	0	58,820,243	0.038892	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,181,220	0	3,181,220	0.204431	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,296,901	0	2,296,901	0.136370	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,010,559	0	1,010,559	0.213343	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,533,324	0	6,533,324	0.010145	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,629,303	0	16,629,303	0.126686	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,494,478	0	13,494,478	0.172968	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,358,473	0	4,358,473	0.157138	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0.000000	0.000000	76.00
200.00		Subtotal (see instructions)	189,660,371	0	189,660,371			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	189,660,371	0	189,660,371			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.541967		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132256		54.00
60.00	06000	LABORATORY	0.126350		60.00
65.00	06500	RESPIRATORY THERAPY	0.038892		65.00
66.00	06600	PHYSICAL THERAPY	0.204431		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.136370		67.00
68.00	06800	SPEECH PATHOLOGY	0.213343		68.00
69.00	06900	ELECTROCARDIOLOGY	0.010145		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.126686		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172968		73.00
74.00	07400	RENAL DIALYSIS	0.157138		74.00
76.00	03950	WOUND CARE	0.000000		76.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part II Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	547,962	3,828	544,134	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,127	3,654	494,473	0	0	54.00
60.00	06000	LABORATORY	1,565,950	24,094	1,541,856	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,287,612	85,902	2,201,710	0	0	65.00
66.00	06600	PHYSICAL THERAPY	650,341	19,931	630,410	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,229	17,444	295,785	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	215,596	8,451	207,145	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	66,278	857	65,421	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,106,694	344,773	1,761,921	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,334,109	68,690	2,265,419	0	0	73.00
74.00	07400	RENAL DIALYSIS	684,882	4,973	679,909	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
200.00		Subtotal (sum of lines 50 thru 199)	11,270,780	582,597	10,688,183	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	11,270,780	582,597	10,688,183	0	0	202.00

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

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet C Part II | Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	547,962	1,011,061	0.541967		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,127	3,766,391	0.132256		54.00
60.00	06000	LABORATORY	1,565,950	12,393,791	0.126350		60.00
65.00	06500	RESPIRATORY THERAPY	2,287,612	58,820,243	0.038892		65.00
66.00	06600	PHYSICAL THERAPY	650,341	3,181,220	0.204431		66.00
67.00	06700	OCCUPATIONAL THERAPY	313,229	2,296,901	0.136370		67.00
68.00	06800	SPEECH PATHOLOGY	215,596	1,010,559	0.213343		68.00
69.00	06900	ELECTROCARDIOLOGY	66,278	6,533,324	0.010145		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,106,694	16,629,303	0.126686		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,334,109	13,494,478	0.172968		73.00
74.00	07400	RENAL DIALYSIS	684,882	4,358,473	0.157138		74.00
76.00	03950	WOUND CARE	0	0	0.000000		76.00
200.00		Subtotal (sum of lines 50 thru 199)	11,270,780	123,495,744			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	11,270,780	123,495,744			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part I Date/Time Prepared: 6/1/2022 10:58 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	1,102,922	0	1,102,922	14,400	76.59	30.00
200.00	Total (lines 30 through 199)	1,102,922		1,102,922	14,400		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	7,819	598,857	30.00
200.00	Total (lines 30 through 199)	7,819	598,857	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part II Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,828	1,011,061	0.003786	665,045	2,518	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,654	3,766,391	0.000970	1,892,148	1,835	54.00
60.00	06000	LABORATORY	24,094	12,393,791	0.001944	6,720,520	13,065	60.00
65.00	06500	RESPIRATORY THERAPY	85,902	58,820,243	0.001460	24,807,374	36,219	65.00
66.00	06600	PHYSICAL THERAPY	19,931	3,181,220	0.006265	1,778,914	11,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,444	2,296,901	0.007595	1,258,409	9,558	67.00
68.00	06800	SPEECH PATHOLOGY	8,451	1,010,559	0.008363	487,251	4,075	68.00
69.00	06900	ELECTROCARDIOLOGY	857	6,533,324	0.000131	3,406,949	446	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,773	16,629,303	0.020733	9,061,686	187,876	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,690	13,494,478	0.005090	7,647,957	38,928	73.00
74.00	07400	RENAL DIALYSIS	4,973	4,358,473	0.001141	2,590,541	2,956	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	582,597	123,495,744		60,316,794	308,621	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part III Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	14,400	0.00	7,819	30.00
200.00		Total (lines 30 through 199)		0	14,400		7,819	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,011,061	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,766,391	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,393,791	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	58,820,243	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,181,220	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,296,901	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,010,559	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,533,324	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,629,303	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,494,478	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,358,473	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	123,495,744		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	665,045	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,892,148	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	6,720,520	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	24,807,374	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,778,914	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,258,409	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	487,251	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,406,949	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	9,061,686	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	7,647,957	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,590,541	0	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	0	0	76.00
200.00		Total (lines 50 through 199)		60,316,794	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part I Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,102,922	0	1,102,922	14,400	76.59	30.00
200.00	Total (lines 30 through 199)	1,102,922		1,102,922	14,400		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	0	0		30.00
200.00	Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part II Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,828	1,011,061	0.003786	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,654	3,766,391	0.000970	0	0	54.00
60.00	06000	LABORATORY	24,094	12,393,791	0.001944	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	85,902	58,820,243	0.001460	0	0	65.00
66.00	06600	PHYSICAL THERAPY	19,931	3,181,220	0.006265	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,444	2,296,901	0.007595	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,451	1,010,559	0.008363	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	857	6,533,324	0.000131	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,773	16,629,303	0.020733	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,690	13,494,478	0.005090	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,973	4,358,473	0.001141	0	0	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	582,597	123,495,744		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part III Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	14,400	0.00	0	30.00
200.00		Total (lines 30 through 199)		0	14,400		0	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,011,061	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,766,391	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,393,791	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	58,820,243	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,181,220	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,296,901	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,010,559	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,533,324	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,629,303	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,494,478	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,358,473	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	123,495,744		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D Part IV Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	0	0	76.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet D-1 Date/Time Prepared: 6/1/2022 10:58 am
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,400	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)	14,400	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7,819	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)	15,445,602	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)	15,445,602	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)	15,445,602	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)	1,072.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,386,738	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)	8,386,738	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/1/2022 10:58 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,976,328	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,363,066	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)	598,857	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	308,621	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	907,478	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,455,588	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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,102,922	15,445,602	0.071407	0	0	90.00
91.00	Nursing Program cost	0	15,445,602	0.000000	0	0	91.00
92.00	Allied health cost	0	15,445,602	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,445,602	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,400	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,400	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)	14,400	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)	0	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)	15,445,602	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)	15,445,602	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)	15,445,602	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)	1,072.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-1 | Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,102,922	15,445,602	0.071407	0	0	90.00
91.00	Nursing Program cost	0	15,445,602	0.000000	0	0	91.00
92.00	Allied health cost	0	15,445,602	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,445,602	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/1/2022 10:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		35,357,826		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.541967	665,045	360,432	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132256	1,892,148	250,248	54.00
60.00	06000	LABORATORY	0.126350	6,720,520	849,138	60.00
65.00	06500	RESPIRATORY THERAPY	0.038892	24,807,374	964,808	65.00
66.00	06600	PHYSICAL THERAPY	0.204431	1,778,914	363,665	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.136370	1,258,409	171,609	67.00
68.00	06800	SPEECH PATHOLOGY	0.213343	487,251	103,952	68.00
69.00	06900	ELECTROCARDIOLOGY	0.010145	3,406,949	34,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.126686	9,061,686	1,147,989	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172968	7,647,957	1,322,852	73.00
74.00	07400	RENAL DIALYSIS	0.157138	2,590,541	407,072	74.00
76.00	03950	WOUND CARE	0.000000	0	0	76.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		60,316,794	5,976,328	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)		60,316,794		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet D-3 | Date/Time Prepared: 6/1/2022 10:58 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.541967	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132256	0	0	54.00
60.00	06000	LABORATORY	0.126350	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.038892	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.204431	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.136370	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.213343	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.010145	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.126686	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172968	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.157138	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	76.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 6/1/2022 10:58 am

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		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		13,943,092		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	10/28/2021	183,483		0	3.50
3.51		01/04/2022	282,417		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)		-465,900		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)		13,477,192		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		548,406		0	6.02
7.00	Total Medicare program liability (see instructions)		12,928,786		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet E-1 Part II Date/Time Prepared: 6/1/2022 10:58 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: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 6/1/2022 10:58 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	12,282,185	1.00
1.01	Full standard payment amount	10,178,338	1.01
1.02	Short stay outlier standard payment amount	2,103,847	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	0	1.04
2.00	Outlier Payments	1,110,374	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	13,392,559	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	13,392,559	7.00
8.00	Primary payer payments	0	8.00
9.00	Subtotal (line 7 less line 8).	13,392,559	9.00
10.00	Deductibles	18,001	10.00
11.00	Subtotal (line 9 minus line 10)	13,374,558	11.00
12.00	Coinsurance	772,284	12.00
13.00	Subtotal (line 11 minus line 12)	12,602,274	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	502,326	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	326,512	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	316,644	16.00
17.00	Subtotal (sum of lines 13 and 15)	12,928,786	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.98	Recovery of accelerated depreciation.	0	21.98
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	12,928,786	22.00
22.01	Sequestration adjustment (see instructions)	0	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	13,477,192	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	-548,406	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	39,784	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	1,110,374	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 (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2024	Period: From 02/01/2021 To 01/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 6/1/2022 10:58 am
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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)	0	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)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet G | Date/Time Prepared: 6/1/2022 10:58 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	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,044,660	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	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	156,632	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,201,292	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	284,766	0	0	0	15.00
16.00	Accumulated depreciation	-275,141	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,785,686	0	0	0	23.00
24.00	Accumulated depreciation	-2,269,907	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)	1,525,404	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	1,092,807	0	0	0	32.00
33.00	Due from owners/officers	16,854,128	0	0	0	33.00
34.00	Other assets	16,538,105	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,485,040	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,211,736	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,825,076	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,332,848	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	852,624	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,010,548	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	266,921	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	266,921	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,277,469	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	35,934,267				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)	35,934,267	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,211,736	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet G-1 | Date/Time Prepared: 6/1/2022 10:58 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		36,426,924		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		55,803				2.00
3.00	Total (sum of line 1 and line 2)		36,482,727		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FUND BALANCE RECON	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)		36,482,727		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ACCOUNT 62101 BAD DEBT REV DED	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)		36,482,727		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	FUND BALANCE RECON		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	ACCOUNT 62101 BAD DEBT REV DED		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: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/1/2022 10:58 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	66,164,627		66,164,627	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				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)	66,164,627		66,164,627	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	66,164,627		66,164,627	17.00
18.00	Ancillary services	123,495,743	0	123,495,743	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	189,660,370	0	189,660,370	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,316,326		29.00
30.00	BAD DEBT ADDED INTO EXPENSE	596,101			30.00
31.00	ROUNDING	1			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)		596,102		36.00
37.00	**DEDUCT**	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)		25,912,428		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-2024 | Period: From 02/01/2021 To 01/31/2022 | Worksheet G-3 | Date/Time Prepared: 6/1/2022 10:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	189,660,370	1.00
2.00	Less contractual allowances and discounts on patients' accounts	161,246,760	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,413,610	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,912,428	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,501,182	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	275	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 REVENUE	0	24.00
24.01	PHYSICIAN REVENUE	0	24.01
24.50	COVID-19 PHE Funding	548,460	24.50
25.00	Total other income (sum of lines 6-24)	548,735	25.00
26.00	Total (line 5 plus line 25)	3,049,917	26.00
27.00	MANAGEMENT FEE	1,037,080	27.00
27.01	INTERCOMPANY INTEREST	-10,712	27.01
27.02	TAXES	776,691	27.02
27.03	INTEREST EXPENSE	1,191,055	27.03
27.04	MEDICARE SPREAD PUSHDOWN	0	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	2,994,114	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	55,803	29.00