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: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 4:29 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/28/2022 Time: 4:29 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF FT WAYNE (15-3030) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	219,134	-892	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	219,134	-892	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2022 4:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46804-	County: ALLEN	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	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060	5	11/01/1993	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)	10/01/2020	09/30/2021	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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

		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.	316	0	0	0	2,030		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 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: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 4:29 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 4:29 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2022 4:29 pm

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	48,682	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	HB1848	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 4:29 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 4:29 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			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.	N			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)	Y	02/22/2022	Y	02/22/2022	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: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 4:29 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2020	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVEN	BAUER	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6159254320	STEVEN_BAUER@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2022 4:29 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2022 4:29 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,140	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)		36	13,140	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)		36	13,140	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)		36				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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2022 4:29 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,109	316	12,325			1.00
2.00	HMO and other (see instructions)	2,086	2,030				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)	5,109	316	12,325			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)	5,109	316	12,325	0.00	115.85	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	115.85	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	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2022 4:29 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	437	23	990	1.00
2.00	HMO and other (see instructions)			149	151		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	437	23	990	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		357,537	357,537	190,872	548,409	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		187,881	187,881	145,869	333,750	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	43,631	33,140	76,771	1,049,308	1,126,079	4.00
5.01	00570	ADMITTING	164,755	233,390	398,145	-187	397,958	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	1,241,270	2,793,409	4,034,679	-1,720,890	2,313,789	5.02
7.00	00700	OPERATION OF PLANT	213,815	663,167	876,982	67,040	944,022	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,644	65,644	0	65,644	8.00
9.00	00900	HOUSEKEEPING	185,414	36,209	221,623	-1,111	220,512	9.00
10.00	01000	DIETARY	469,219	289,912	759,131	-224,641	534,490	10.00
11.00	01100	CAFETERIA	0	0	0	224,335	224,335	11.00
13.00	01300	NURSING ADMINISTRATION	437,963	62,964	500,927	-324	500,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,571	79,743	87,314	-77,622	9,692	14.00
15.00	01500	PHARMACY	190,918	528,569	719,487	-505,417	214,070	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,618	111,470	258,088	-913	257,175	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,388,935	1,136,098	4,525,033	461,823	4,986,856	30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,486	10,486	0	10,486	54.00
60.00	06000	LABORATORY	39,958	47,472	87,430	0	87,430	60.00
65.00	06500	RESPIRATORY THERAPY	9,079	24,947	34,026	-13,488	20,538	65.00
66.00	06600	PHYSICAL THERAPY	1,033,941	166,071	1,200,012	-73,142	1,126,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	834,309	69,808	904,117	0	904,117	67.00
68.00	06800	SPEECH PATHOLOGY	331,644	38,962	370,606	0	370,606	68.00
69.00	06900	ELECTROCARDIOLOGY	36	145	181	0	181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,899	5,899	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	473,174	473,174	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	110,330	8,558	118,888	-29	118,859	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	176,135	176,135	0	176,135	76.01
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,849,406	7,121,717	15,971,123	556	15,971,679	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	260	3,733	3,993	-556	3,437	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	8,849,666	7,125,450	15,975,116	0	15,975,116	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-25,293	523,116	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	40,955	374,705	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,126,079	4.00
5.01	00570	ADMITTING	0	397,958	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	119,667	2,433,456	5.02
7.00	00700	OPERATION OF PLANT	-7,637	936,385	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,644	8.00
9.00	00900	HOUSEKEEPING	0	220,512	9.00
10.00	01000	DIETARY	0	534,490	10.00
11.00	01100	CAFETERIA	-75,205	149,130	11.00
13.00	01300	NURSING ADMINISTRATION	0	500,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,692	14.00
15.00	01500	PHARMACY	0	214,070	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12	257,163	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-359,964	4,626,892	30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,486	54.00
60.00	06000	LABORATORY	0	87,430	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,538	65.00
66.00	06600	PHYSICAL THERAPY	0	1,126,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	904,117	67.00
68.00	06800	SPEECH PATHOLOGY	0	370,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0	181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,899	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	473,174	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	118,859	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	176,135	76.01
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-307,489	15,664,190	118.00
	NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,437	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-307,489	15,667,627	200.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-6 | Date/Time Prepared: 2/28/2022 4:29 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,049,528	1.00
	0		0	1,049,528	
	B - RENTAL AND LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,322	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	145,869	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	0		0	155,191	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,732	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	153,818	2.00
	0		0	181,550	
	D - REPAIRS & MAINTENANCE COSTS				
1.00	OPERATION OF PLANT	7.00	0	67,040	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	67,040	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,899	1.00
	0		0	5,899	
	F - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	473,174	1.00
	0		0	473,174	
	G - PHYSICIAN DIRECTORS				
1.00	ADULTS & PEDIATRICS	30.00	0	473,645	1.00
	0		0	473,645	
	H - DIETARY				
1.00	CAFETERIA	11.00	138,810	85,525	1.00
	0		138,810	85,525	
500.00	Grand Total: Increases		138,810	2,491,552	500.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-6 | Date/Time Prepared: 2/28/2022 4:29 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	1,049,528	0	1.00
	0		0	1,049,528		
	B - RENTAL AND LEASE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	220	10	1.00
2.00	ADMITTING	5.01	0	187	10	2.00
3.00	ADMIN AND GENERAL - OTHER	5.02	0	8,091	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	80	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	53,505	0	5.00
6.00	PHARMACY	15.00	0	30,879	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	913	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	63	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	13,016	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	48,127	0	10.00
11.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	29	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	81	0	12.00
	0		0	155,191		
	C - OTHER CAPITAL COSTS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	181,550	12	1.00
2.00		0.00	0	0	13	2.00
	0		0	181,550		
	D - REPAIRS & MAINTENANCE COSTS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	8,076	0	1.00
2.00	HOUSEKEEPING	9.00	0	1,111	0	2.00
3.00	DIETARY	10.00	0	306	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	244	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,218	0	5.00
6.00	PHARMACY	15.00	0	1,364	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	11,759	0	7.00
8.00	RESPIRATORY THERAPY	65.00	0	472	0	8.00
9.00	PHYSICAL THERAPY	66.00	0	25,015	0	9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	475	0	10.00
	0		0	67,040		
	E - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,899	0	1.00
	0		0	5,899		
	F - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	473,174	0	1.00
	0		0	473,174		
	G - PHYSICIAN DIRECTORS					
1.00	ADMIN AND GENERAL - OTHER	5.02	0	473,645	0	1.00
	0		0	473,645		
	H - DIETARY					
1.00	DIETARY	10.00	138,810	85,525	0	1.00
	0		138,810	85,525		
500.00	Grand Total: Decreases		138,810	2,491,552		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2022 4:29 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	900,000	0	0	0	0	1.00
2.00	Land Improvements	283,590	3,979	0	3,979	0	2.00
3.00	Buildings and Fixtures	12,325,830	0	0	0	663,298	3.00
4.00	Building Improvements	316,943	855,861	0	855,861	0	4.00
5.00	Fixed Equipment	0	891,944	0	891,944	243,687	5.00
6.00	Movable Equipment	0	1,061,951	0	1,061,951	0	6.00
7.00	HIT designated Assets	7,715	541,232	0	541,232	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,834,078	3,354,967	0	3,354,967	906,985	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,834,078	3,354,967	0	3,354,967	906,985	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	900,000	0	1.00
2.00	Land Improvements	287,569	0	2.00
3.00	Buildings and Fixtures	11,662,532	0	3.00
4.00	Building Improvements	1,172,804	0	4.00
5.00	Fixed Equipment	648,257	0	5.00
6.00	Movable Equipment	1,061,951	0	6.00
7.00	HIT designated Assets	548,947	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,282,060	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,282,060	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2022 4:29 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	357,537	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	175,843	12,038	0	0	0	2.00
3.00	Total (sum of lines 1-2)	533,380	12,038	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	357,537	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	187,881	2.00
3.00	Total (sum of lines 1-2)	0	545,418	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-7 Part III | Date/Time Prepared: 2/28/2022 4:29 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	13,598,579	0	13,598,579	0.999433	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,715	0	7,715	0.000567	0	2.00
3.00	Total (sum of lines 1-2)	13,606,294	0	13,606,294	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	289,355	9,322	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	216,798	157,907	2.00
3.00	Total (sum of lines 1-2)	0	0	0	506,153	167,229	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	42,889	27,732	153,818	0	523,116	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	374,705	2.00
3.00	Total (sum of lines 1-2)	42,889	27,732	153,818	0	897,821	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8 | Date/Time Prepared: 2/28/2022 4:29 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-359,964			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	774,533			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-75,205	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-8,918	CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-947	ADMIN AND GENERAL - OTHER	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-80,613	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-8,547	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELANEOUS INCOME	B	-21	ADMIN AND GENERAL - OTHER	5.02	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8 | Date/Time Prepared: 2/28/2022 4:29 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MARKETING EXPENSE	A	-525,610	ADMIN AND GENERAL - OTHER	5.02	0	33.01
33.02	PATIENT TELEPHONE EXPENSE	A	-7,224	ADMIN AND GENERAL - OTHER	5.02	0	33.02
33.03	PATIENT TV CABLE EXPENSE	A	-7,637	OPERATION OF PLANT	7.00	0	33.03
33.04	PHYSICIAN RECRUITING EXPENSE	A	-6,503	ADMIN AND GENERAL - OTHER	5.02	0	33.04
33.05	LOBBYING FEES SXPENSE	A	0	ADMIN AND GENERAL - OTHER	5.02	0	33.05
33.06	CHARITABLE CONTRIBUTIONS	A	-821	ADMIN AND GENERAL - OTHER	5.02	0	33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-307,489				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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8-1 Date/Time Prepared: 2/28/2022 4:29 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	42,889	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	72	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	9	0	4.02
4.03	5.02	ADMIN AND GENERAL - OTHER	PASI Operating Costs	6,182	4,140	4.03
4.04	5.02	ADMIN AND GENERAL - OTHER	Shared Service Center Alloca	319,997	90,327	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	21,277	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	49,493	0	4.06
4.07	5.02	ADMIN AND GENERAL - OTHER	Non-Capital Home Office Cost	532,988	0	4.07
4.08	5.02	ADMIN AND GENERAL - OTHER	Malpractice Costs	48,682	90,000	4.08
4.09	5.02	ADMIN AND GENERAL - OTHER	HIIM Allocation	0	61,462	4.09
4.10	5.02	ADMIN AND GENERAL - OTHER	PASI Lien Unit Collection Fe	0	1,127	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,021,589	247,056	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	LUTHERAN	100.00	7.00
8.00	G	HOSPITAL LAUNDR	100.00	LAUNDRY	100.00	8.00
9.00	B		0.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2022 4:29 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	42,889	11	4.00
4.01	72	9	4.01
4.02	9	9	4.02
4.03	2,042	0	4.03
4.04	229,670	0	4.04
4.05	21,277	9	4.05
4.06	49,493	9	4.06
4.07	532,988	0	4.07
4.08	-41,318	0	4.08
4.09	-61,462	0	4.09
4.10	-1,127	0	4.10
5.00	774,533		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.

	Type of Business	
6.00	HEALTHCARE	6.00
7.00	HOSPITAL	7.00
8.00	CONSOL LAUNDRY	8.00
9.00	DEBT COLLECTION	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2022 4:29 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	473,645	280,184	193,461	211,500	1,118	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			473,645	280,184	193,461		1,118	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	113,681	5,684	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			113,681	5,684	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	113,681	79,780	359,964	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	113,681	79,780	359,964	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	523,116	523,116				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	374,705		374,705			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,126,079	2,110	1,861	1,130,050		4.00
5.01	00570	ADMITTING	397,958	10,870	9,588	21,143	439,559	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	2,433,456	41,171	36,314	159,288	0	5.02
7.00	00700	OPERATION OF PLANT	936,385	95,829	84,525	27,438	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,644	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	220,512	10,353	9,132	23,794	0	9.00
10.00	01000	DIETARY	534,490	0	0	42,400	0	10.00
11.00	01100	CAFETERIA	149,130	39,999	35,281	17,813	0	11.00
13.00	01300	NURSING ADMINISTRATION	500,603	1,120	988	56,202	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,692	7,907	6,974	972	0	14.00
15.00	01500	PHARMACY	214,070	3,350	2,955	24,500	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	257,163	3,841	3,388	18,815	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,489	2,196	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,626,892	66,605	58,748	434,890	156,295	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,486	3,704	3,267	0	7,576	54.00
60.00	06000	LABORATORY	87,430	0	0	5,128	21,271	60.00
65.00	06500	RESPIRATORY THERAPY	20,538	861	760	1,165	117	65.00
66.00	06600	PHYSICAL THERAPY	1,126,870	86,915	76,662	132,683	67,819	66.00
67.00	06700	OCCUPATIONAL THERAPY	904,117	41,033	36,193	107,064	68,899	67.00
68.00	06800	SPEECH PATHOLOGY	370,606	3,109	2,743	42,559	19,748	68.00
69.00	06900	ELECTROCARDIOLOGY	181	0	0	5	161	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,899	0	0	0	690	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	473,174	0	0	0	82,503	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	118,859	3,549	3,130	14,158	8,378	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	176,135	0	0	0	6,102	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,664,190	424,815	374,705	1,130,017	439,559	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,437	0	0	33	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	98,301	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,667,627	523,116	374,705	1,130,050	439,559	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	Subtotal	ADMIN AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER	2,670,229	2,670,229				5.02
7.00	00700	OPERATION OF PLANT	1,144,177	235,063	1,379,240			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,644	13,486	0	79,130		8.00
9.00	00900	HOUSEKEEPING	263,791	54,194	38,268	0	356,253	9.00
10.00	01000	DIETARY	576,890	118,518	0	0	0	10.00
11.00	01100	CAFETERIA	242,223	49,763	147,851	0	53,878	11.00
13.00	01300	NURSING ADMINISTRATION	558,913	114,825	4,139	0	1,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,545	5,248	29,226	0	10,650	14.00
15.00	01500	PHARMACY	244,875	50,308	12,385	0	4,513	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,207	58,183	14,199	0	5,174	16.00
17.00	01700	SOCIAL SERVICE	4,685	963	9,201	0	3,353	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,343,430	1,097,775	246,195	44,386	89,716	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,033	5,143	13,690	0	4,989	54.00
60.00	06000	LABORATORY	113,829	23,385	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,441	4,816	3,184	0	1,160	65.00
66.00	06600	PHYSICAL THERAPY	1,490,949	306,305	321,267	16,477	117,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,157,306	237,760	151,671	18,267	55,270	67.00
68.00	06800	SPEECH PATHOLOGY	438,765	90,141	11,493	0	4,188	68.00
69.00	06900	ELECTROCARDIOLOGY	347	71	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,589	1,354	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555,677	114,160	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	148,074	30,421	13,117	0	4,780	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	182,237	37,439	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,565,856	2,649,321	1,015,886	79,130	356,253	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,470	713	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	98,301	20,195	363,354	0	0	194.02
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,667,627	2,670,229	1,379,240	79,130	356,253	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	695,408					10.00
11.00	01100	CAFETERIA	0	493,715				11.00
13.00	01300	NURSING ADMINISTRATION	0	35,146	714,531			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,050	0	71,719		14.00
15.00	01500	PHARMACY	0	15,257	0	101	327,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,192	0	49	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	695,408	260,848	714,531	59,558	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	7,906	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	741	0	3,668	0	65.00
66.00	06600	PHYSICAL THERAPY	0	71,960	0	4,054	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	63,189	0	1,884	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	21,125	0	390	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	2,005	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	327,439	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	6,239	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	695,408	493,653	714,531	71,709	327,439	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	62	0	10	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	695,408	493,715	714,531	71,719	327,439	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part I Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	371,004					16.00
17.00	01700	SOCIAL SERVICE	0	18,202				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	131,954	18,202	8,702,003	0	8,702,003	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,393	0	55,248	0	55,248	54.00
60.00	06000	LABORATORY	17,951	0	163,071	0	163,071	60.00
65.00	06500	RESPIRATORY THERAPY	99	0	37,109	0	37,109	65.00
66.00	06600	PHYSICAL THERAPY	57,234	0	2,385,320	0	2,385,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,145	0	1,743,492	0	1,743,492	67.00
68.00	06800	SPEECH PATHOLOGY	16,665	0	582,767	0	582,767	68.00
69.00	06900	ELECTROCARDIOLOGY	136	0	554	0	554	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	583	0	10,531	0	10,531	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,625	0	1,066,901	0	1,066,901	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,070	0	209,701	0	209,701	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	5,149	0	224,825	0	224,825	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	371,004	18,202	15,181,522	0	15,181,522	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,255	0	4,255	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	481,850	0	481,850	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	371,004	18,202	15,667,627	0	15,667,627	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			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	2,110	1,861	3,971	3,971	4.00
5.01	00570	ADMITTING	0	10,870	9,588	20,458	74	5.01
5.02	00590	ADMIN AND GENERAL - OTHER	0	41,171	36,314	77,485	560	5.02
7.00	00700	OPERATION OF PLANT	0	95,829	84,525	180,354	96	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,353	9,132	19,485	84	9.00
10.00	01000	DIETARY	0	0	0	0	149	10.00
11.00	01100	CAFETERIA	0	39,999	35,281	75,280	63	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,120	988	2,108	198	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,907	6,974	14,881	3	14.00
15.00	01500	PHARMACY	0	3,350	2,955	6,305	86	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,841	3,388	7,229	66	16.00
17.00	01700	SOCIAL SERVICE	0	2,489	2,196	4,685	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	66,605	58,748	125,353	1,528	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,704	3,267	6,971	0	54.00
60.00	06000	LABORATORY	0	0	0	0	18	60.00
65.00	06500	RESPIRATORY THERAPY	0	861	760	1,621	4	65.00
66.00	06600	PHYSICAL THERAPY	0	86,915	76,662	163,577	466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,033	36,193	77,226	376	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,109	2,743	5,852	150	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
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,549	3,130	6,679	50	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	424,815	374,705	799,520	3,971	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	98,301	0	98,301	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	523,116	374,705	897,821	3,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	ADMITTING	ADMIN AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING	20,532					5.01
5.02	00590	ADMIN AND GENERAL - OTHER	0	78,045				5.02
7.00	00700	OPERATION OF PLANT	0	6,871	187,321			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	394	0	394		8.00
9.00	00900	HOUSEKEEPING	0	1,584	5,197	0	26,350	9.00
10.00	01000	DIETARY	0	3,464	0	0	0	10.00
11.00	01100	CAFETERIA	0	1,455	20,080	0	3,985	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,356	562	0	112	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	153	3,969	0	788	14.00
15.00	01500	PHARMACY	0	1,470	1,682	0	334	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,701	1,928	0	383	16.00
17.00	01700	SOCIAL SERVICE	0	28	1,250	0	248	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,285	32,083	33,437	221	6,636	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	354	150	1,859	0	369	54.00
60.00	06000	LABORATORY	995	684	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	5	141	432	0	86	65.00
66.00	06600	PHYSICAL THERAPY	3,172	8,953	43,633	82	8,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,222	6,950	20,599	91	4,088	67.00
68.00	06800	SPEECH PATHOLOGY	924	2,635	1,561	0	310	68.00
69.00	06900	ELECTROCARDIOLOGY	8	2	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32	40	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,858	3,337	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	392	889	1,781	0	354	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	285	1,094	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,532	77,434	137,970	394	26,350	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	590	49,351	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,532	78,045	187,321	394	26,350	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	3,613					10.00
11.00	01100	CAFETERIA	0	100,863				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,180	13,516			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	215	0	20,009		14.00
15.00	01500	PHARMACY	0	3,117	0	28	13,022	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,082	0	14	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,613	53,289	13,516	16,617	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	1,615	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	151	0	1,023	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,701	0	1,131	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,909	0	525	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,316	0	109	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	559	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,022	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,275	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,613	100,850	13,516	20,006	13,022	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13	0	3	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,613	100,863	13,516	20,009	13,022	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B Part II Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,403					16.00
17.00	01700	SOCIAL SERVICE	0	6,211				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,760	6,211	304,549	0	304,549	30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	231	0	9,934	0	9,934	54.00
60.00	06000	LABORATORY	649	0	3,961	0	3,961	60.00
65.00	06500	RESPIRATORY THERAPY	4	0	3,467	0	3,467	65.00
66.00	06600	PHYSICAL THERAPY	2,069	0	246,441	0	246,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,102	0	128,088	0	128,088	67.00
68.00	06800	SPEECH PATHOLOGY	603	0	16,460	0	16,460	68.00
69.00	06900	ELECTROCARDIOLOGY	5	0	15	0	15	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21	0	652	0	652	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,517	0	22,734	0	22,734	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	256	0	11,676	0	11,676	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	186	0	1,565	0	1,565	76.01
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,403	6,211	749,542	0	749,542	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	37	0	37	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	148,242	0	148,242	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,403	6,211	897,821	0	897,821	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	728,820					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		591,864				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,940	2,940	8,806,035			4.00
5.01	00570	ADMITTING	15,144	15,144	164,755	67,401,160		5.01
5.02	00590	ADMIN AND GENERAL - OTHER	57,360	57,360	1,241,270	0	-2,670,229	5.02
7.00	00700	OPERATION OF PLANT	133,512	133,512	213,815	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	14,424	14,424	185,414	0	0	9.00
10.00	01000	DIETARY	0	0	330,409	0	0	10.00
11.00	01100	CAFETERIA	55,728	55,728	138,810	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,560	1,560	437,963	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,016	11,016	7,571	0	0	14.00
15.00	01500	PHARMACY	4,668	4,668	190,918	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,352	5,352	146,618	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,468	3,468	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,796	92,796	3,388,935	23,969,062	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160	5,160	0	1,161,560	0	54.00
60.00	06000	LABORATORY	0	0	39,958	3,261,439	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,200	1,200	9,079	17,986	0	65.00
66.00	06600	PHYSICAL THERAPY	121,092	121,092	1,033,941	10,398,544	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,168	57,168	834,309	10,564,081	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,332	4,332	331,644	3,027,876	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	36	24,657	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,864	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,649,980	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,944	4,944	110,330	1,284,572	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	935,539	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,864	591,864	8,805,775	67,401,160	-2,670,229	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	260	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	136,956	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	523,116	374,705	1,130,050	439,559		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.717757	0.633093	0.128327	0.006522		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,971	20,532		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000451	0.000305		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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	ADMIN AND GENERAL - OTHER (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUN)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	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
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER	12,997,398					5.02
7.00	00700	OPERATION OF PLANT	1,144,177	519,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,644	0	133,494			8.00
9.00	00900	HOUSEKEEPING	263,791	14,424	0	368,484		9.00
10.00	01000	DIETARY	576,890	0	0	0	74,168	10.00
11.00	01100	CAFETERIA	242,223	55,728	0	55,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	558,913	1,560	0	1,560	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,545	11,016	0	11,016	0	14.00
15.00	01500	PHARMACY	244,875	4,668	0	4,668	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,207	5,352	0	5,352	0	16.00
17.00	01700	SOCIAL SERVICE	4,685	3,468	0	3,468	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,343,430	92,796	74,881	92,796	74,168	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,033	5,160	0	5,160	0	54.00
60.00	06000	LABORATORY	113,829	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,441	1,200	0	1,200	0	65.00
66.00	06600	PHYSICAL THERAPY	1,490,949	121,092	27,797	121,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,157,306	57,168	30,816	57,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	438,765	4,332	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	347	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,589	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555,677	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	148,074	4,944	0	4,944	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	182,237	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,895,627	382,908	133,494	368,484	74,168	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,470	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	98,301	136,956	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,670,229	1,379,240	79,130	356,253	695,408	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.205443	2.653078	0.592761	0.966807	9.376119	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,045	187,321	394	26,350	3,613	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006005	0.360327	0.002951	0.071509	0.048714	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMIN AND GENERAL - OTHER						5.02
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	7,993					11.00
13.00	01300	NURSING ADMINISTRATION	569	2,900,670				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17	0	211,060			14.00
15.00	01500	PHARMACY	247	0	297	473,174		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165	0	144	0	67,401,160	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,223	2,900,670	175,275	0	23,969,062	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,161,560	54.00
60.00	06000	LABORATORY	128	0	0	0	3,261,439	60.00
65.00	06500	RESPIRATORY THERAPY	12	0	10,795	0	17,986	65.00
66.00	06600	PHYSICAL THERAPY	1,165	0	11,930	0	10,398,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,023	0	5,543	0	10,564,081	67.00
68.00	06800	SPEECH PATHOLOGY	342	0	1,149	0	3,027,876	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	24,657	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,899	0	105,864	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	473,174	12,649,980	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	101	0	0	0	1,284,572	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	935,539	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,992	2,900,670	211,032	473,174	67,401,160	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	0	28	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	493,715	714,531	71,719	327,439	371,004	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	61.768422	0.246333	0.339804	0.692005	0.005504	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,863	13,516	20,009	13,022	13,403	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.618917	0.004660	0.094802	0.027521	0.000199	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet B-1 | Date/Time Prepared: 2/28/2022 4:29 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS %)	
			17.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	ADMIN AND GENERAL - OTHER		5.02
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	12,325	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	12,325	30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	76.01
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,325	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	194.01
194.02	07952	TENANT LEASED SPACE	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	18,202	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.476836	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,211	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.503935	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,702,003		8,702,003	79,780	8,781,783	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,248		55,248	0	55,248	54.00
60.00	06000	LABORATORY	163,071		163,071	0	163,071	60.00
65.00	06500	RESPIRATORY THERAPY	37,109	0	37,109	0	37,109	65.00
66.00	06600	PHYSICAL THERAPY	2,385,320	0	2,385,320	0	2,385,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,743,492	0	1,743,492	0	1,743,492	67.00
68.00	06800	SPEECH PATHOLOGY	582,767	0	582,767	0	582,767	68.00
69.00	06900	ELECTROCARDIOLOGY	554		554	0	554	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,531		10,531	0	10,531	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,066,901		1,066,901	0	1,066,901	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	209,701		209,701	0	209,701	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	224,825		224,825	0	224,825	76.01
200.00		Subtotal (see instructions)	15,181,522	0	15,181,522	79,780	15,261,302	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,181,522	0	15,181,522	79,780	15,261,302	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,969,062		23,969,062			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,158,660	2,900	1,161,560	0.047564	0.000000	54.00
60.00	06000	LABORATORY	3,258,639	2,800	3,261,439	0.050000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	17,986	0	17,986	2.063216	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,398,544	0	10,398,544	0.229390	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,564,081	0	10,564,081	0.165040	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,027,876	0	3,027,876	0.192467	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,657	0	24,657	0.022468	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,515	32,349	105,864	0.099477	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,635,065	14,915	12,649,980	0.084340	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,281,672	2,900	1,284,572	0.163246	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	935,539	0	935,539	0.240316	0.000000	76.01
200.00		Subtotal (see instructions)	67,345,296	55,864	67,401,160			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	67,345,296	55,864	67,401,160			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047564	54.00
60.00	06000	LABORATORY	0.050000	60.00
65.00	06500	RESPIRATORY THERAPY	2.063216	65.00
66.00	06600	PHYSICAL THERAPY	0.229390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.165040	67.00
68.00	06800	SPEECH PATHOLOGY	0.192467	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099477	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.084340	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.163246	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.240316	76.01
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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,702,003		8,702,003	79,780	8,781,783	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,248		55,248	0	55,248	54.00
60.00	06000	LABORATORY	163,071		163,071	0	163,071	60.00
65.00	06500	RESPIRATORY THERAPY	37,109	0	37,109	0	37,109	65.00
66.00	06600	PHYSICAL THERAPY	2,385,320	0	2,385,320	0	2,385,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,743,492	0	1,743,492	0	1,743,492	67.00
68.00	06800	SPEECH PATHOLOGY	582,767	0	582,767	0	582,767	68.00
69.00	06900	ELECTROCARDIOLOGY	554		554	0	554	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,531		10,531	0	10,531	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,066,901		1,066,901	0	1,066,901	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	209,701		209,701	0	209,701	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	224,825		224,825	0	224,825	76.01
200.00		Subtotal (see instructions)	15,181,522	0	15,181,522	79,780	15,261,302	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,181,522	0	15,181,522	79,780	15,261,302	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,969,062		23,969,062			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,158,660	2,900	1,161,560	0.047564	0.000000	54.00
60.00	06000	LABORATORY	3,258,639	2,800	3,261,439	0.050000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	17,986	0	17,986	2.063216	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	10,398,544	0	10,398,544	0.229390	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,564,081	0	10,564,081	0.165040	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,027,876	0	3,027,876	0.192467	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	24,657	0	24,657	0.022468	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,515	32,349	105,864	0.099477	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,635,065	14,915	12,649,980	0.084340	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,281,672	2,900	1,284,572	0.163246	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	935,539	0	935,539	0.240316	0.000000	76.01
200.00		Subtotal (see instructions)	67,345,296	55,864	67,401,160			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	67,345,296	55,864	67,401,160			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part I | Date/Time Prepared: 2/28/2022 4:29 pm

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		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047564	54.00
60.00	06000	LABORATORY	0.050000	60.00
65.00	06500	RESPIRATORY THERAPY	2.063216	65.00
66.00	06600	PHYSICAL THERAPY	0.229390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.165040	67.00
68.00	06800	SPEECH PATHOLOGY	0.192467	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099477	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.084340	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.163246	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.240316	76.01
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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part II | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,248	9,934	45,314	0	0	54.00
60.00	06000	LABORATORY	163,071	3,961	159,110	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	37,109	3,467	33,642	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,385,320	246,441	2,138,879	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,743,492	128,088	1,615,404	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	582,767	16,460	566,307	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	554	15	539	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,531	652	9,879	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,066,901	22,734	1,044,167	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	209,701	11,676	198,025	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	224,825	1,565	223,260	0	0	76.01
200.00		Subtotal (sum of lines 50 thru 199)	6,479,519	444,993	6,034,526	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	6,479,519	444,993	6,034,526	0	0	202.00

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

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet C Part II | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,248	1,161,560	0.047564	54.00
60.00	06000	LABORATORY	163,071	3,261,439	0.050000	60.00
65.00	06500	RESPIRATORY THERAPY	37,109	17,986	2.063216	65.00
66.00	06600	PHYSICAL THERAPY	2,385,320	10,398,544	0.229390	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,743,492	10,564,081	0.165040	67.00
68.00	06800	SPEECH PATHOLOGY	582,767	3,027,876	0.192467	68.00
69.00	06900	ELECTROCARDIOLOGY	554	24,657	0.022468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,531	105,864	0.099477	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,066,901	12,649,980	0.084340	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	209,701	1,284,572	0.163246	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	224,825	935,539	0.240316	76.01
200.00		Subtotal (sum of lines 50 thru 199)	6,479,519	43,432,098		200.00
201.00		Less Observation Beds	0	0		201.00
202.00		Total (line 200 minus line 201)	6,479,519	43,432,098		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3030

Period: From 10/01/2020 To 09/30/2021

Worksheet D Part I

Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	304,549	0	304,549	12,325	24.71	30.00
200.00	Total (lines 30 through 199)	304,549		304,549	12,325		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	5,109	126,243	30.00
200.00	Total (lines 30 through 199)	5,109	126,243	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part II Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,934	1,161,560	0.008552	400,412	3,424	54.00
60.00	06000	LABORATORY	3,961	3,261,439	0.001214	1,448,069	1,758	60.00
65.00	06500	RESPIRATORY THERAPY	3,467	17,986	0.192761	6,882	1,327	65.00
66.00	06600	PHYSICAL THERAPY	246,441	10,398,544	0.023700	4,384,277	103,907	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,088	10,564,081	0.012125	4,470,020	54,199	67.00
68.00	06800	SPEECH PATHOLOGY	16,460	3,027,876	0.005436	1,031,999	5,610	68.00
69.00	06900	ELECTROCARDIOLOGY	15	24,657	0.000608	9,841	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	652	105,864	0.006159	14,765	91	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,734	12,649,980	0.001797	4,711,350	8,466	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,676	1,284,572	0.009089	495,710	4,506	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	1,565	935,539	0.001673	464,770	778	76.01
200.00		Total (lines 50 through 199)	444,993	43,432,098		17,438,095	184,072	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part III Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	12,325	0.00	5,109	30.00
200.00		Total (lines 30 through 199)		0	12,325		5,109	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: 15-3030

Period: From 10/01/2020 To 09/30/2021

Worksheet D Part IV

Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
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
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,161,560	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,261,439	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,986	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,398,544	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,564,081	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,027,876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,657	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,864	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,649,980	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,284,572	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	935,539	0.000000	76.01
200.00		Total (lines 50 through 199)	0	0	0	43,432,098		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030

Period: From 10/01/2020 To 09/30/2021

Worksheet D Part IV

Date/Time Prepared: 2/28/2022 4:29 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	400,412	0	1,610	0	54.00
60.00	06000	LABORATORY	0.000000	1,448,069	0	69	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,882	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,384,277	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,470,020	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,031,999	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,841	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	14,765	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,711,350	0	696	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	495,710	0	1,360	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.000000	464,770	0	0	0	76.01
200.00		Total (lines 50 through 199)		17,438,095	0	3,735	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-3030

Period: From 10/01/2020 To 09/30/2021

Worksheet D Part V

Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047564	1,610	0	0	77	54.00
60.00	06000	LABORATORY	0.050000	69	0	0	3	60.00
65.00	06500	RESPIRATORY THERAPY	2.063216	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.229390	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.165040	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.192467	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022468	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099477	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.084340	696	0	7,717	59	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.163246	1,360	0	0	222	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.240316	0	0	0	0	76.01
200.00		Subtotal (see instructions)		3,735	0	7,717	361	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,735	0	7,717	361	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part V Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	651	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	76.01
200.00		Subtotal (see instructions)	0	651	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	651	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part I | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	304,549	0	304,549	12,325	24.71	30.00
200.00	Total (lines 30 through 199)	304,549		304,549	12,325		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	316	7,808	30.00
200.00	Total (lines 30 through 199)	316	7,808	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part II | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,934	1,161,560	0.008552	15,990	137	54.00
60.00	06000	LABORATORY	3,961	3,261,439	0.001214	91,922	112	60.00
65.00	06500	RESPIRATORY THERAPY	3,467	17,986	0.192761	0	0	65.00
66.00	06600	PHYSICAL THERAPY	246,441	10,398,544	0.023700	249,996	5,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	128,088	10,564,081	0.012125	252,394	3,060	67.00
68.00	06800	SPEECH PATHOLOGY	16,460	3,027,876	0.005436	49,988	272	68.00
69.00	06900	ELECTROCARDIOLOGY	15	24,657	0.000608	586	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	652	105,864	0.006159	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,734	12,649,980	0.001797	267,344	480	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,676	1,284,572	0.009089	28,703	261	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	1,565	935,539	0.001673	28,341	47	76.01
200.00		Total (lines 50 through 199)	444,993	43,432,098		985,264	10,294	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part III Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	12,325	0.00	316	30.00
200.00		Total (lines 30 through 199)		0	12,325		316	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D Part IV | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
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
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030

Period: From 10/01/2020 To 09/30/2021

Worksheet D Part IV

Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,161,560	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	3,261,439	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,986	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,398,544	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,564,081	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,027,876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,657	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	105,864	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,649,980	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,284,572	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	935,539	0.000000	76.01
200.00		Total (lines 50 through 199)	0	0	0	43,432,098		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030

Period: From 10/01/2020 To 09/30/2021

Worksheet D Part IV

Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	15,990	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	91,922	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	249,996	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	252,394	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	49,988	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	586	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	267,344	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	28,703	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.000000	28,341	0	0	0	76.01
200.00		Total (lines 50 through 199)		985,264	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,325	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)	12,325	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)	5,109	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)	8,781,783	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)	8,781,783	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)	8,781,783	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)	712.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,640,265	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,640,265	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/28/2022 4:29 pm

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)	2,639,374	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,279,639	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)	126,243	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	184,072	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	310,315	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,969,324	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	304,549	8,781,783	0.034680	0	0	90.00
91.00	Nursing Program cost	0	8,781,783	0.000000	0	0	91.00
92.00	Allied health cost	0	8,781,783	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,781,783	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,325	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)	12,325	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)	316	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)	8,781,783	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)	8,781,783	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)	8,781,783	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)	712.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	225,156	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)	225,156	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	148,038	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	373,194	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)	7,808	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,294	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	18,102	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	355,092	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-1 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	304,549	8,781,783	0.034680	0	0	90.00
91.00	Nursing Program cost	0	8,781,783	0.000000	0	0	91.00
92.00	Allied health cost	0	8,781,783	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,781,783	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,915,231		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047564	400,412	19,045	54.00
60.00	06000	LABORATORY	0.050000	1,448,069	72,403	60.00
65.00	06500	RESPIRATORY THERAPY	2.063216	6,882	14,199	65.00
66.00	06600	PHYSICAL THERAPY	0.229390	4,384,277	1,005,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.165040	4,470,020	737,732	67.00
68.00	06800	SPEECH PATHOLOGY	0.192467	1,031,999	198,626	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022468	9,841	221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099477	14,765	1,469	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.084340	4,711,350	397,355	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.163246	495,710	80,923	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.240316	464,770	111,692	76.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,438,095	2,639,374	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)		17,438,095		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet D-3 | Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		550,766		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.047564	15,990	761	54.00
60.00	06000	LABORATORY	0.050000	91,922	4,596	60.00
65.00	06500	RESPIRATORY THERAPY	2.063216	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.229390	249,996	57,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.165040	252,394	41,655	67.00
68.00	06800	SPEECH PATHOLOGY	0.192467	49,988	9,621	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022468	586	13	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099477	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.084340	267,344	22,548	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.163246	28,703	4,686	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.240316	28,341	6,811	76.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		985,264	148,038	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)		985,264		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E Part B Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	651	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	361	2.00
3.00	OPPS payments	590	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	651	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,717	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	7,717	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	7,717	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,066	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	651	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	590	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	50	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	25	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,166	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,166	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,166	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,166	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,166	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,058	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-892	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2022 4:29 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,142,618		2,058	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,142,618		2,058	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		219,134		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		892	6.02
7.00	Total Medicare program liability (see instructions)		9,361,752		1,166	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: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part II Date/Time Prepared: 2/28/2022 4:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 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 from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-3 Part III Date/Time Prepared: 2/28/2022 4:29 pm

		Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,780,703	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0271	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	566,355	3.00
4.00	Outlier Payments	137,655	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	33.767123	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	9,484,713	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	9,484,713	17.00
18.00	Primary payer payments	18,603	18.00
19.00	Subtotal (line 17 less line 18).	9,466,110	19.00
20.00	Deductibles	59,400	20.00
21.00	Subtotal (line 19 minus line 20)	9,406,710	21.00
22.00	Coinsurance	44,958	22.00
23.00	Subtotal (line 21 minus line 22)	9,361,752	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	9,361,752	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	9,361,752	32.00
32.01	Sequestration adjustment (see instructions)	0	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	9,142,618	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	219,134	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	57,953	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	137,655	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet E-3 Part VII Date/Time Prepared: 2/28/2022 4:29 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		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	550,766		8.00
9.00	Ancillary service charges	985,264	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,536,030	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,536,030	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,536,030	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: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G | Date/Time Prepared: 2/28/2022 4:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-22,271	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,007,058	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-549,742	0	0	0	6.00
7.00	Inventory	22,316	0	0	0	7.00
8.00	Prepaid expenses	154,962	0	0	0	8.00
9.00	Other current assets	2,963	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)	3,615,286	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	900,000	0	0	0	12.00
13.00	Land improvements	287,568	0	0	0	13.00
14.00	Accumulated depreciation	-194,177	0	0	0	14.00
15.00	Buildings	11,662,532	0	0	0	15.00
16.00	Accumulated depreciation	-3,546,813	0	0	0	16.00
17.00	Leasehold improvements	1,259,966	0	0	0	17.00
18.00	Accumulated depreciation	-356,209	0	0	0	18.00
19.00	Fixed equipment	575,001	0	0	0	19.00
20.00	Accumulated depreciation	-219,547	0	0	0	20.00
21.00	Automobiles and trucks	113,428	0	0	0	21.00
22.00	Accumulated depreciation	-113,428	0	0	0	22.00
23.00	Major movable equipment	600,900	0	0	0	23.00
24.00	Accumulated depreciation	-328,983	0	0	0	24.00
25.00	Minor equipment depreciable	233,838	0	0	0	25.00
26.00	Accumulated depreciation	-156,733	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)	10,717,343	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	809,023	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	809,023	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,141,652	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	470,902	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,095,474	0	0	0	38.00
39.00	Payroll taxes payable	87,029	0	0	0	39.00
40.00	Notes and loans payable (short term)	44,957	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	10,483,428	0	0	0	43.00
44.00	Other current liabilities	739,740	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,921,530	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	105,422	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	105,422	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,026,952	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,114,700				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)	2,114,700	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,141,652	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-1 | Date/Time Prepared: 2/28/2022 4:29 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-2,706,425		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,821,125				2.00
3.00	Total (sum of line 1 and line 2)		2,114,700		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		2,114,700		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,114,700		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/28/2022 4:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	23,969,062		23,969,062	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)	23,969,062		23,969,062	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)	23,969,062		23,969,062	17.00
18.00	Ancillary services	43,399,749	32,349	43,432,098	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)	67,368,811	32,349	67,401,160	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,975,116		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,975,116		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-3030 | Period: From 10/01/2020 To 09/30/2021 | Worksheet G-3 | Date/Time Prepared: 2/28/2022 4:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,401,160	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,778,873	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,622,287	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,975,116	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,647,171	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	173,954	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	173,954	25.00
26.00	Total (line 5 plus line 25)	4,821,125	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,821,125	29.00